

## CERTIFICATE OF DEATH

04454  
Reg. Dist. No.

4465

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District Columbia</u> b. COUNTY <u>47X-3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. STREET ADDRESS <u>5110 Fort Totten Dr. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Spavelly</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 Sept 22 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Barber</u>				10b. KIND OF BUSINESS, OR INDUSTRY <u>Barber</u>			
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>			
13. FATHER'S NAME <u>Amos Adams</u>				14. MOTHER'S MAIDEN NAME <u>Helen Wagner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-14-4907A</u>			
17. INFORMANT <u>Mrs. Genevieve L. Adams</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary obstruction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>5 yrs.</u> (c) <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>59</u> , to <u>4/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/19</u> , 19 <u>59</u> , and that death occurred at <u>9:25</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. G. Hardy</u>				ADDRESS (Street, city or town, state) <u>8913 Georgia Ave Silver Spring Md.</u>			
DATE SIGNED <u>4/20/59</u>							
PHYSICIAN'S NAME (Type) <u>CYRIL GEORGE HARDY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond E. Giska.</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24a. REC'D BY REGISTRAR <u>APR 22 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Adams</u>			

TO HOSPITAL OR FUNERAL HOME: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	
22. SIGNATURE OF CLERK <i>John Doe</i>		23. SIGNATURE OF REGISTRAR <i>John Doe</i>		24. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
25. SIGNATURE OF ASSISTANT <i>John Doe</i>		26. SIGNATURE OF CHIEF <i>John Doe</i>		27. SIGNATURE OF DEPUTY <i>John Doe</i>	
28. SIGNATURE OF CLERK <i>John Doe</i>		29. SIGNATURE OF REGISTRAR <i>John Doe</i>		30. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
31. SIGNATURE OF ASSISTANT <i>John Doe</i>		32. SIGNATURE OF CHIEF <i>John Doe</i>		33. SIGNATURE OF DEPUTY <i>John Doe</i>	
34. SIGNATURE OF CLERK <i>John Doe</i>		35. SIGNATURE OF REGISTRAR <i>John Doe</i>		36. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
37. SIGNATURE OF ASSISTANT <i>John Doe</i>		38. SIGNATURE OF CHIEF <i>John Doe</i>		39. SIGNATURE OF DEPUTY <i>John Doe</i>	
40. SIGNATURE OF CLERK <i>John Doe</i>		41. SIGNATURE OF REGISTRAR <i>John Doe</i>		42. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
43. SIGNATURE OF ASSISTANT <i>John Doe</i>		44. SIGNATURE OF CHIEF <i>John Doe</i>		45. SIGNATURE OF DEPUTY <i>John Doe</i>	
46. SIGNATURE OF CLERK <i>John Doe</i>		47. SIGNATURE OF REGISTRAR <i>John Doe</i>		48. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
49. SIGNATURE OF ASSISTANT <i>John Doe</i>		50. SIGNATURE OF CHIEF <i>John Doe</i>		51. SIGNATURE OF DEPUTY <i>John Doe</i>	
52. SIGNATURE OF CLERK <i>John Doe</i>		53. SIGNATURE OF REGISTRAR <i>John Doe</i>		54. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
55. SIGNATURE OF ASSISTANT <i>John Doe</i>		56. SIGNATURE OF CHIEF <i>John Doe</i>		57. SIGNATURE OF DEPUTY <i>John Doe</i>	
58. SIGNATURE OF CLERK <i>John Doe</i>		59. SIGNATURE OF REGISTRAR <i>John Doe</i>		60. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
61. SIGNATURE OF ASSISTANT <i>John Doe</i>		62. SIGNATURE OF CHIEF <i>John Doe</i>		63. SIGNATURE OF DEPUTY <i>John Doe</i>	
64. SIGNATURE OF CLERK <i>John Doe</i>		65. SIGNATURE OF REGISTRAR <i>John Doe</i>		66. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
67. SIGNATURE OF ASSISTANT <i>John Doe</i>		68. SIGNATURE OF CHIEF <i>John Doe</i>		69. SIGNATURE OF DEPUTY <i>John Doe</i>	
70. SIGNATURE OF CLERK <i>John Doe</i>		71. SIGNATURE OF REGISTRAR <i>John Doe</i>		72. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
73. SIGNATURE OF ASSISTANT <i>John Doe</i>		74. SIGNATURE OF CHIEF <i>John Doe</i>		75. SIGNATURE OF DEPUTY <i>John Doe</i>	
76. SIGNATURE OF CLERK <i>John Doe</i>		77. SIGNATURE OF REGISTRAR <i>John Doe</i>		78. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
79. SIGNATURE OF ASSISTANT <i>John Doe</i>		80. SIGNATURE OF CHIEF <i>John Doe</i>		81. SIGNATURE OF DEPUTY <i>John Doe</i>	
82. SIGNATURE OF CLERK <i>John Doe</i>		83. SIGNATURE OF REGISTRAR <i>John Doe</i>		84. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
85. SIGNATURE OF ASSISTANT <i>John Doe</i>		86. SIGNATURE OF CHIEF <i>John Doe</i>		87. SIGNATURE OF DEPUTY <i>John Doe</i>	
88. SIGNATURE OF CLERK <i>John Doe</i>		89. SIGNATURE OF REGISTRAR <i>John Doe</i>		90. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
91. SIGNATURE OF ASSISTANT <i>John Doe</i>		92. SIGNATURE OF CHIEF <i>John Doe</i>		93. SIGNATURE OF DEPUTY <i>John Doe</i>	
94. SIGNATURE OF CLERK <i>John Doe</i>		95. SIGNATURE OF REGISTRAR <i>John Doe</i>		96. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
97. SIGNATURE OF ASSISTANT <i>John Doe</i>		98. SIGNATURE OF CHIEF <i>John Doe</i>		99. SIGNATURE OF DEPUTY <i>John Doe</i>	
100. SIGNATURE OF CLERK <i>John Doe</i>		101. SIGNATURE OF REGISTRAR <i>John Doe</i>		102. SIGNATURE OF ARCHIVIST <i>John Doe</i>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 449 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04455

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>41 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>N. Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp</b>			1. STREET ADDRESS <b>4003 Jones Bridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sarah R. Addison</b>			4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1959</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/1878</b>		9. AGE (In years last birthday) <b>80</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Walter D. Addison</b>			14. MOTHER'S MAIDEN NAME <b>Mary Keppler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-36-7537</b>		17. INFORMANT <b>Hosp. Record</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> <b>4739 Baltimore Ave.</b> <b>Hyattsville, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>APR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4492

## CERTIFICATE OF DEATH

04456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7402 Arlington Road</b>		/d. STREET ADDRESS <b>7402 Arlington Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CORDELIA</b> Middle <b>G.</b> Last <b>ALBAUGH</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Noah Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Lindsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Louise A. Kolb-daughter-as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Bronchial Pneumonia -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Failure &amp; decompensation</b> DUE TO <b>3 days</b> (c) <b>Cardiovascular Disease -</b> DUE TO <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis - Jan. 1959.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , 19____, to <b>death</b> , 19____, that I last saw the deceased alive on <b>21 April</b> , 19 <b>59</b> , and that death occurred at <b>10:30</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7936 Old Georgetown Rd. Beth. Md</b> DATE SIGNED ACTUAL SIGNATURE <b>John G. Ball</b> M.D. PHYSICIAN'S NAME (Type) <b>John G. Ball</b> <b>7936 Old Georgetown Rd. Beth. Md 4/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Central Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Colburn S. Hanna</b>	

CERTIFICATE OF DEATH

1432

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

CORRECTION

SEX

EDUCATION

RELIGION

NO.

DATE OF BIRTH

PLACE OF BIRTH

AGE AT BIRTH

EDUCATION

RELIGION

SEX

EDUCATION

RELIGION

SEX

EDUCATION

RELIGION

SEX

EDUCATION

RELIGION

SEX

EDUCATION

RELIGION

4493

## CERTIFICATE OF DEATH

04457

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10231 Carroll Place</u> <u>Carroll Hall Sanatorium</u>		d. STREET ADDRESS <u>213 W. 29th St.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle Last <u>ALBERS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1886</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Anton D. Albers</u>		14. MOTHER'S MAIDEN NAME <u>Diana Laupus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. INFORMANT Address <u>Mr. Anton D. Albers - Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ESSENTIAL HYPERTENSION</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 9, 1959</u> , to <u>APRIL 22, 1959</u> that I last saw the deceased alive on <u>APRIL 22, 1959</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry Albers</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norway Dr. Chevy Chase, Md.</u> DATE SIGNED <u>4/22/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Nunn Co. 2901-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4466

## CERTIFICATE OF DEATH

04458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>		d. STREET ADDRESS <u>1022 Woodside Pkwy.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Eugene Ammerman</u>		4. DATE OF DEATH Month Day Year <u>4 - 1 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-79</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>George W. Ammerman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Schade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 8</u> , 19 <u>54</u> , to <u>31 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>31 March</u> , 19 <u>59</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.		ADDRESS (Street, city or town, state) <u>8801 Colesville Road</u> DATE SIGNED <u>4/1/59</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. James Co 2901 14th NW</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 2 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles B. Miller</u>	

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4494

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN TB <b>9 days 10 hrs. 56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph M Armiger</b>				4. DATE OF DEATH Month Day Year <b>April 28 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/09</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Treas. Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Friendship Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph F. Armiger</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Atwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Wife (Same as Above)</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>572.1</b> DUE TO <b>Respiratory tuberculosis Gen. Pericarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rest operative state - Rheumatoid</b> DUE TO <b>colostomy</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4/1/59</b> , 19 <b>59</b> to <b>4/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/28</b> , 19 <b>59</b> , and that death occurred at <b>7:20</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. T. R. Coleman</b> M.D. <b>1835 Eye St NW</b>				ADDRESS (Street, city or town, state) <b>Washington</b> DATE SIGNED <b>May 1 1959</b>			
PHYSICIAN'S NAME (Type) <b>W. T. R. COLEMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc.</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4495

## CERTIFICATE OF DEATH

04460

Reg. Dist. No. 215

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1654 34th Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Baby</u> <u>Girl</u> <u>ARMSTRONG</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>24</u> Year <u>19 59</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Caucasia n</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-24-59</u>	
<b>9. AGE</b> (In years lost birthday) yrs. <u>1</u> <u>55</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Bethesda, Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Peter F.C. ARMSTRONG</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Claire CHARLETON</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme Immaturity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>April 24</u> , 19 <u>59</u> , to <u>April 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>59</u> , and that death occurred at <u>2245P</u> M, from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <u>U. S. Naval Hospital, NNMC</u> <b>DATE SIGNED</b> <u>4-24-59</u>							
<b>ACTUAL SIGNATURE</b> <u>Kenneth</u>				<b>PHYSICIAN'S NAME (Type)</b> <u>K. W. SELL, LT MC USN</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>4-28-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>	
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Arlington Virginia</u>				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur L. Kenna</u>			
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>APR 28 '59</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest Middle Bagley		4. DATE OF DEATH April 8 1959	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/97
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pethesda Bldg Supply, Wilson, NC</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Ida Bagley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>INEORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Gastric Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> (c) <u>10/27/58</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/30/37</u> , 19___, to <u>4/8/59</u> , 19___, that I last saw the deceased alive on <u>4/6/59</u> , 19___, and that death occurred at <u>1:37A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.		ADDRESS (Street, city or town, state) <u>Norbeck, Rt. 1 Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Webster Sewell, M.D.</u>		DATE SIGNED <u>4/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-13-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Trager's Funeral Home</u> ADDRESS <u>389 P St NW, DC</u>		24a. REC'D BY REGISTRAR <u>APR 9 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10001

DEPARTMENT OF HEALTH

2882

11



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4496

CERTIFICATE OF DEATH

04462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b> 83X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Rest Home</b>		d. STREET ADDRESS <b>311 Graham Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LEONARD J. BAHLMAN</b> First Middle Last		4. DATE OF DEATH <b>4-26-1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/15/1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR <b>2</b> Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant-Tailor</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John Henry Bahlman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine L. Hornig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Wm. S. Bahlman-son-5312 Reno Rd. N. W.</b>		Address <b>Washington D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PLEURAL EFFUSION (LEFT)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 15, 1959</b> , to <b>4-26</b> , 1959, that I last saw the deceased alive on <b>4-26</b> , 1959, and that death occurred at <b>5:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D.		ADDRESS (Street, city or town, state) <b>5206 Newway Dr</b> DATE SIGNED <b>8/26/59</b>	
PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b>		<b>Cherry Choe, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>

MEDICAL CERTIFICATION

04903

EXHIBIT A-10

1998

Revised

Amended

Proposed

Amendment

General and Special

and Special

1998

1998

1998

John Henry

John Henry

John Henry

John Henry

John Henry

John Henry

4497

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Springs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1022--Quebec Terr. Apt. 302</b>		d. STREET ADDRESS <b>1022 Quebec Terr. Apt. 302</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>G.</b> Last <b>BALL</b>		4. DATE OF DEATH Month <b>18</b> Day <b>10th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1901</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodward and Lothrop</b>	
11. BIRTHPLACE (State or foreign country) <b>Leesburg, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert F. Green</b>		14. MOTHER'S MAIDEN NAME <b>Julia M. Royston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Barbara B. Betts</b>		Address <b>1022--Quebec Terrace.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>170x</b> DUE TO <b>Barcinomatous Metastases to Brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Breast</b> DUE TO (c) <b>1 month</b> <b>3 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 11</b> , 19 <b>58</b> , to <b>April 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 7</b> , 19 <b>59</b> , and that death occurred at <b>10:12 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lendall C. Gay</b>		ADDRESS (Street, city or town, state) <b>403 East Capitol St Wash DC</b>	
PHYSICIAN'S NAME (Type) <b>LENDALL C. GAY M.D.</b>		DATE SIGNED <b>4/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		ADDRESS <b>1661--Good Hope Rd., SE Washington: 20 DC</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <b>JOHN DOE</b>		2. SEX <b>MALE</b>		3. RACE <b>WHITE</b>		4. DATE OF BIRTH <b>1/1/1900</b>		5. PLACE OF BIRTH <b>BALTIMORE, MD</b>	
6. DATE OF DEATH <b>1/15/1950</b>		7. PLACE OF DEATH <b>BALTIMORE, MD</b>		8. CAUSE OF DEATH <b>HEART DISEASE</b>		9. MANNER OF DEATH <b>NATURAL</b>		10. SIGNATURE OF REGISTRAR <b>[Signature]</b>	
11. SIGNATURE OF DECEASED <b>[Signature]</b>		12. SIGNATURE OF NEXT OF KIN <b>[Signature]</b>		13. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		14. SIGNATURE OF MORTUARY <b>[Signature]</b>		15. SIGNATURE OF BURIAL <b>[Signature]</b>	
16. SIGNATURE OF FUNERAL HOME <b>[Signature]</b>		17. SIGNATURE OF CEMETERY <b>[Signature]</b>		18. SIGNATURE OF INTERMENT <b>[Signature]</b>		19. SIGNATURE OF RECORDS <b>[Signature]</b>		20. SIGNATURE OF ARCHIVES <b>[Signature]</b>	
21. SIGNATURE OF VITALS <b>[Signature]</b>		22. SIGNATURE OF DEATH <b>[Signature]</b>		23. SIGNATURE OF DEATH <b>[Signature]</b>		24. SIGNATURE OF DEATH <b>[Signature]</b>		25. SIGNATURE OF DEATH <b>[Signature]</b>	
26. SIGNATURE OF DEATH <b>[Signature]</b>		27. SIGNATURE OF DEATH <b>[Signature]</b>		28. SIGNATURE OF DEATH <b>[Signature]</b>		29. SIGNATURE OF DEATH <b>[Signature]</b>		30. SIGNATURE OF DEATH <b>[Signature]</b>	
31. SIGNATURE OF DEATH <b>[Signature]</b>		32. SIGNATURE OF DEATH <b>[Signature]</b>		33. SIGNATURE OF DEATH <b>[Signature]</b>		34. SIGNATURE OF DEATH <b>[Signature]</b>		35. SIGNATURE OF DEATH <b>[Signature]</b>	
36. SIGNATURE OF DEATH <b>[Signature]</b>		37. SIGNATURE OF DEATH <b>[Signature]</b>		38. SIGNATURE OF DEATH <b>[Signature]</b>		39. SIGNATURE OF DEATH <b>[Signature]</b>		40. SIGNATURE OF DEATH <b>[Signature]</b>	
41. SIGNATURE OF DEATH <b>[Signature]</b>		42. SIGNATURE OF DEATH <b>[Signature]</b>		43. SIGNATURE OF DEATH <b>[Signature]</b>		44. SIGNATURE OF DEATH <b>[Signature]</b>		45. SIGNATURE OF DEATH <b>[Signature]</b>	
46. SIGNATURE OF DEATH <b>[Signature]</b>		47. SIGNATURE OF DEATH <b>[Signature]</b>		48. SIGNATURE OF DEATH <b>[Signature]</b>		49. SIGNATURE OF DEATH <b>[Signature]</b>		50. SIGNATURE OF DEATH <b>[Signature]</b>	
51. SIGNATURE OF DEATH <b>[Signature]</b>		52. SIGNATURE OF DEATH <b>[Signature]</b>		53. SIGNATURE OF DEATH <b>[Signature]</b>		54. SIGNATURE OF DEATH <b>[Signature]</b>		55. SIGNATURE OF DEATH <b>[Signature]</b>	
56. SIGNATURE OF DEATH <b>[Signature]</b>		57. SIGNATURE OF DEATH <b>[Signature]</b>		58. SIGNATURE OF DEATH <b>[Signature]</b>		59. SIGNATURE OF DEATH <b>[Signature]</b>		60. SIGNATURE OF DEATH <b>[Signature]</b>	
61. SIGNATURE OF DEATH <b>[Signature]</b>		62. SIGNATURE OF DEATH <b>[Signature]</b>		63. SIGNATURE OF DEATH <b>[Signature]</b>		64. SIGNATURE OF DEATH <b>[Signature]</b>		65. SIGNATURE OF DEATH <b>[Signature]</b>	
66. SIGNATURE OF DEATH <b>[Signature]</b>		67. SIGNATURE OF DEATH <b>[Signature]</b>		68. SIGNATURE OF DEATH <b>[Signature]</b>		69. SIGNATURE OF DEATH <b>[Signature]</b>		70. SIGNATURE OF DEATH <b>[Signature]</b>	
71. SIGNATURE OF DEATH <b>[Signature]</b>		72. SIGNATURE OF DEATH <b>[Signature]</b>		73. SIGNATURE OF DEATH <b>[Signature]</b>		74. SIGNATURE OF DEATH <b>[Signature]</b>		75. SIGNATURE OF DEATH <b>[Signature]</b>	
76. SIGNATURE OF DEATH <b>[Signature]</b>		77. SIGNATURE OF DEATH <b>[Signature]</b>		78. SIGNATURE OF DEATH <b>[Signature]</b>		79. SIGNATURE OF DEATH <b>[Signature]</b>		80. SIGNATURE OF DEATH <b>[Signature]</b>	
81. SIGNATURE OF DEATH <b>[Signature]</b>		82. SIGNATURE OF DEATH <b>[Signature]</b>		83. SIGNATURE OF DEATH <b>[Signature]</b>		84. SIGNATURE OF DEATH <b>[Signature]</b>		85. SIGNATURE OF DEATH <b>[Signature]</b>	
86. SIGNATURE OF DEATH <b>[Signature]</b>		87. SIGNATURE OF DEATH <b>[Signature]</b>		88. SIGNATURE OF DEATH <b>[Signature]</b>		89. SIGNATURE OF DEATH <b>[Signature]</b>		90. SIGNATURE OF DEATH <b>[Signature]</b>	
91. SIGNATURE OF DEATH <b>[Signature]</b>		92. SIGNATURE OF DEATH <b>[Signature]</b>		93. SIGNATURE OF DEATH <b>[Signature]</b>		94. SIGNATURE OF DEATH <b>[Signature]</b>		95. SIGNATURE OF DEATH <b>[Signature]</b>	
96. SIGNATURE OF DEATH <b>[Signature]</b>		97. SIGNATURE OF DEATH <b>[Signature]</b>		98. SIGNATURE OF DEATH <b>[Signature]</b>		99. SIGNATURE OF DEATH <b>[Signature]</b>		100. SIGNATURE OF DEATH <b>[Signature]</b>	

4498

## CERTIFICATE OF DEATH

04464  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's</b>				c. LENGTH OF STAY IN 1b <b>25 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mary A. Simpson Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>ELLEN</b> Last <b>BARNES</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1870</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Glover</b>				14. MOTHER'S MAIDEN NAME <b>Martha Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Margaret L. Heard, Landover Hills, Maryland.</b>				Address <b>6911 Annapolis Road,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>5 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>24 Feb</b> , 19 <b>59</b> , to <b>4 April</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 April</b> , 19 <b>59</b> , and that death occurred at <b>10<sup>30</sup> A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>BARNESVILLE, Md.</b> DATE SIGNED <b>4 Apr 59</b> ACTUAL SIGNATURE <b>Gordon M. Smith</b> M.D. <b>BARNESVILLE, Md. 4 Apr 59</b> PHYSICIAN'S NAME (Type) <b>GORDON M. SMITH, M.D.</b> <b>Barnesville, Maryland.</b> <b>4/4/59.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Maryland.</b>				24a. REC'D BY REGISTRAR <b>APR 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1011

CERTIFICATE OF

1908

THIS CERTIFICATE IS ISSUED TO THE  
HONORABLE JAMES A. HARRIS  
OF THE STATE OF MISSISSIPPI  
IN WITNESS WHEREOF  
I HAVE HEREUNTO SET MY HAND  
AND SEAL OF OFFICE  
THIS 10TH DAY OF JANUARY  
1908

Attest my hand and seal of office  
this 10th day of January  
1908

W. A. CHAMBERS, Sec'y. of State  
J. A. HARRIS, Hon. Sec'y. of State



4499

CERTIFICATE OF DEATH

04465

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1622 Rhode Island Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lelia Montague BARNETT</b>				4. DATE OF DEATH Month Day Year <b>April 3 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-22-71</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Walter Powhatan MONTAGUE</b>				14. MOTHER'S MAIDEN NAME <b>Lelia SINCLAIR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(D) Mrs. Lelia Gordon Noyes, Washington, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Staphylococcal</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Strangulating intestinal obstruction</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23, 1959</b> , to <b>April 3, 1959</b> , that I last saw the deceased alive on <b>April 3, 1959</b> , and that death occurred at <b>10:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NMMC</b> DATE SIGNED <b>4-3-59</b>							
ACTUAL SIGNATURE <b>W. D. Hogfer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>W. D. HOGFER, LT, MC, USN</b>				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Pawler's &amp; Sons, 1756 Penn. Ave., NW,</b>				24. REC'D BY REGISTRAR <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04466

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ormond Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>483 S. Halifax Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Elise</u> First <u>Bamford</u> Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	
11. IF UNDER 24 HRS. Hours <u>14</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>Australia</u>	
13. FATHER'S NAME <u>Samuel Carey</u>		14. MOTHER'S MAIDEN NAME <u>Harvey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daughter Ruth D. Snively</u>		Address <u>DL 6 4612</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> (c) <u>fracture of skull</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound fracture &amp; dislocation left wrist</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Arose from bed to go to bath room &amp; fell down stairs</u>	
20c. TIME OF INJURY Month, Day, Year <u>4/19 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Washington</u> (County) <u>DC.</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaut</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaut</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE OF MARYLAND

NAME OF DECEASED  
J. C. SMITH

DATE OF DEATH  
JAN 15 1921

PLACE OF DEATH  
HOME

AGE  
65

SEX  
MALE

RACE  
WHITE

RELIGION  
METHODIST

EDUCATION  
HIGH SCHOOL

OCCUPATION  
FARMER

CAUSE OF DEATH  
HEART DISEASE

DETAILS OF CASE  
SEE REPORT

DATE OF EXAMINATION  
JAN 15 1921

PLACE OF EXAMINATION  
HOME

NAME OF EXAMINER  
J. C. SMITH

DATE OF DEATH  
JAN 15 1921

PLACE OF DEATH  
HOME

AGE  
65

SEX  
MALE

RACE  
WHITE

RELIGION  
METHODIST

EDUCATION  
HIGH SCHOOL

OCCUPATION  
FARMER

CAUSE OF DEATH  
HEART DISEASE

DETAILS OF CASE  
SEE REPORT

Robert A. Humphrey, Registrar, Baltimore, Md.  
JAN 15 1921  
J. C. SMITH, M.D., Baltimore, Md.

4501

Reg. Dist. No.

04467

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Virginia Va - 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Private residence"</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Berry</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander C. Darn</u>		14. MOTHER'S MAIDEN NAME <u>Beth E. Darby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Samuel Berry</u>		Address <u>Virginia Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1 Sanguine due to occlusive Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Gen</u> (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 months Unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 2</u> , 19 <u>59</u> , to <u>Apr. 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr. 9</u> , 19 <u>59</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>105 Russell Avenue, Gaithersburg, Md.</u> DATE SIGNED <u>4-11-59</u>			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Herndon Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Monroe &amp; King</u> ADDRESS <u>211 E. Potomac St. Vienna Va</u>		24a. REC'D BY REGISTRAR <u>GAITHERSBURG</u>	24b. REGISTRAR'S SIGNATURE <u>GAITHERSBURG</u>

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

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4502

CERTIFICATE OF DEATH

04468

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>2½ yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 SILVER SPRING</b>				d. STREET ADDRESS <b>8554 11th AVENUE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8554 11th AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>ELMER</b> Last <b>BLUNDON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/5/96</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Metal Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Research</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Brooke Blundon</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Barron</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>WW #1</b>				16. SOCIAL SECURITY NO. <b>214-03-8035</b>		17. INFORMANT Address <b>Mrs. Mary D. Blundon, 8554 11th Ave. Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Apr. 18, 1959</b> to <b>Apr. 29, 1959</b> , that I last saw the deceased alive on <b>Apr. 28, 1959</b> , and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6480 N. H. Ave. Takoma Park, Ind.</b> DATE SIGNED <b>Apr. 29/59</b>							
ACTUAL SIGNATURE <b>Thomas J. Kelly</b> M.D.				PHYSICIAN'S NAME (Type) <b>THOMAS J. KELLY</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death).

note:

4/29/59 Mr. Broschart was notified thru Silver Spring  
Police Dept. & apprived.

Thomas J. Kelly, m.d.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4503

## CERTIFICATE OF DEATH

04469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>40 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>204 Gloucester Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nonna</b> Middle <b>Lee</b> Last <b>Brady</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1959</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11, 1946</b>	
9. AGE (In years last birthday) <b>12</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Bernard M. Brady, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Fauble</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G.I. and Pulmonary Hemorrhage</b> 2043 DUE TO (b) <b>Acute Lymphatic Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>1 3/4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1959</b> , to <b>April 21, 1959</b> , that I last saw the deceased alive on <b>April 21, 1959</b> , and that death occurred at <b>5:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/22/59</b> ACTUAL SIGNATURE <b>Nathan S. Taylor</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Nathan S. Taylor, M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Small</b>		22b. DATE THEREOF <b>4-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Galen M. Taylor Sons</b>				ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>APR 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

CERTIFICATE OF DEATH

1902

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "Name of Deceased", "Date of Death", and "Place of Death".

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4504

## CERTIFICATE OF DEATH

04470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>140 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b> d. STREET ADDRESS <b>9902 Sidney Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Ruby</b> Last <b>Brooker</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 25, 1920</b>
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Research Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Research</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fitzu Parler</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Appleby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO <b>2041</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myelocytic Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pylonephritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b> <b>2 Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 8</b> , 19 <b>58</b> , to <b>April 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 27</b> , 19 <b>59</b> , and that death occurred at <b>2:50p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-28-59</b> ACTUAL SIGNATURE <b>I. Bernard Weinstein</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>I. Bernard Weinstein, M. D.</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>5/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Daughters of Confederacy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. George, South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>APR 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1855		New York	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		2 Weeks		10:00 AM	
Place of Death		Occupation		Education		Marital Status		Religion	
Home		Teacher		High School		Married		Catholic	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition	
Jan 15, 1900		Jan 16, 1900		Jan 16, 1900				Jan 16, 1900	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 2, Film G241, 4/15/59 fcy  
4505  
CERTIFICATE OF DEATH

04471  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home for the Aged</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Florence</u> Last <u>Broughton</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1859</u>
9. AGE (In years last birthday) <u>100</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomac Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Broughton</u>		14. MOTHER'S MAIDEN NAME <u>Liza Ann Greene</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Asbury Methodist Home, Gaithersburg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-8</u> , 19 <u>56</u> to <u>4-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-8</u> , 19 <u>59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		M.D. <u>10128 CEDAR LANE</u> <u>Kensington, Md</u>	
PHYSICIAN'S NAME (Type) <u>Sarah Elizabeth Glover, M.D.</u>		DATE SIGNED <u>4-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner &amp; Sons - Balto.</u>		ADDRESS <u>Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1911, Oct. 1st

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of birth: [illegible]

5. Place of birth: [illegible]

6. Date of death: [illegible]

7. Cause of death: [illegible]

8. Place of death: [illegible]

9. Name of physician: [illegible]

10. Name of undertaker: [illegible]

11. Name of funeral home: [illegible]

12. Name of cemetery: [illegible]

13. Name of church: [illegible]

14. Name of minister: [illegible]

15. Name of sexton: [illegible]

16. Name of registrar: [illegible]

17. Name of coroner: [illegible]

18. Name of jury: [illegible]

19. Name of jury: [illegible]

20. Name of jury: [illegible]

*Procurator*  
*Procurator*

21. Name of jury: [illegible]

22. Name of jury: [illegible]

23. Name of jury: [illegible]

24. Name of jury: [illegible]

25. Name of jury: [illegible]

26. Name of jury: [illegible]

27. Name of jury: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)  
ISM 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 6, See: Birth Cert. et  
4506  
CERTIFICATE OF DEATH

04472  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 days</u> x <u>Boyd's</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1 Route #1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle <u>Steward</u> Last <u>Burdette Jr</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1959</u>
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melvin Burdette</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy D. MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>170</u>	
INFORMANT <u>Melvin Burdette (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 754.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COARCTATION OF AORTA &amp; PATENT DUCTUS</u> DUE TO <u>ARTERIOSCLEROSIS</u> (c) <u>RIGHT VENTRICULAR HYPERTROPHY</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>FROM BIRTH</u> <u>FROM BIRTH</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>17 HOURS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 22, 1959</u> to <u>APRIL 30, 1959</u> , that I last saw the deceased alive on <u>APRIL 30, 1959</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ira W. Pearlman</u> M.D.		ADDRESS (Street, city or town, state) <u>4700 Bradley Blvd.</u> DATE SIGNED <u>5/1/59</u>	
PHYSICIAN'S NAME (Type) <u>Ira W. Pearlman</u>		<u>Cheryl Chase, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Clarksburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Smith</u> ADDRESS <u>Dalhousie MS</u>		24a. REC'D BY REGISTRAR <u>May 4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

2074181XV4

04175

CENTRAL AL OF EX-17

4208

4208  
JAN 10 1941  
KNOX

No. 10  
Methuen Roadster  
Name —  
Methuen Roadster  
1934

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4507 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG241 4-22-59 et

04473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN <u>20 A.</u>		d. STREET ADDRESS <u>10717 McArthur Blvd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brickyard Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Douglas Caldwell</u>		4. DATE OF DEATH <u>Apr 14 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-32</u>
9. AGE (If years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic Helper</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Farmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-42-1972</u>	
17. INFORMANT <u>Police record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon-monoxide poisoning</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in auto with hose attached to exhaust</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-14-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda 14, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	





4508

## CERTIFICATE OF DEATH

04474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>27 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
				d. STREET ADDRESS <b>4616 De Russey Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Mary Canan</b>				4. DATE OF DEATH Month Day Year <b>April 7 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1, 1874</b>	
				9. AGE (In years lost birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>1 6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chamberling Mfg. Co Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Mrs. Marion H. Gates (friend)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>4343</b> DUE TO <b>Constrictive pericarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Inanition.</b> (c) <b>Inanition.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left hydrothorax late ectasis of left lung due to compression</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April 5, 1959</b> to <b>April 7, 1959</b> , that I last saw the deceased alive on <b>April 7, 1959</b> , and that death occurred at <b>12:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George A. Gray, Jr.</b>				DATE SIGNED <b>April 9, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Geo A. GRAY, M.D.</b>				ADDRESS (Street, city or town, state) <b>104 Chevy Chase Rd. Chevy Chase, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within any event within 72 hours after death.



4467

## CERTIFICATE OF DEATH

04475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>8561 11<sup>th</sup> Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Jack</u> First Also known as <u>Medley Jacob Caplan</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-96</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upshur Pharmacy</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Alexander Caplan</u>		14. MOTHER'S MAIDEN NAME <u>Clara (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>025-18-6269</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic, hypertensive C-V disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 1945, to <u>March</u> , 1959, that I last saw the deceased alive on <u>March 21</u> , 1959, and that death occurred at <u>10:55 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Ordman</u>		ADDRESS (Street, city or town, state) <u>1726 M St. NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES W. ORDMAN</u>		DATE SIGNED <u>4-1-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Humphrey</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>	
ADDRESS <u>4349 44<sup>th</sup> Ave. S.S. Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Perard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK	
JAMES M. SMITH		Male		45		White		Farmer		Maryland		Jan 1, 1900		Jan 1, 1900		Home		Heart Disease		Natural		J. M. Smith		D. M. Smith		A. M. Smith	
15. PLACE OF INTERMENT		16. NAME OF INTERMENT PLACE		17. DATE OF INTERMENT		18. SIGNATURE OF MINISTER		19. SIGNATURE OF CLERK		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF CLERK		22. SIGNATURE OF PHYSICIAN		23. SIGNATURE OF CLERK		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF CLERK		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF CLERK		28. SIGNATURE OF PHYSICIAN	
St. John's Church		St. John's Church		Jan 1, 1900		J. M. Smith		A. M. Smith		D. M. Smith		J. M. Smith		D. M. Smith		A. M. Smith		J. M. Smith		D. M. Smith		A. M. Smith		J. M. Smith		D. M. Smith	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF VITALS, BUREAU OF VITALS, MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4509

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04476

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. R-29 and Norwood Road</b>				d. STREET ADDRESS <b>10604 Inwood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ray Earle Carrick</b>				4. DATE OF DEATH Month Day Year <b>April 9 19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/22/32</b>		9. AGE (in years last birthday) <b>27</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins Physics Lab.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earle R. Carrick</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth M. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-44-6072</b>		17. INFORMANT Address <b>Mr. Earle R. Carrick, 9319 Wire Ave. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b> DUE TO <b>Compound fracture of skull</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO <b>auto accident</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple injuries, extreme</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car in head on collision</b>					
20c. TIME OF INJURY Hour <b>5:45</b> p.m. Month, Day, Year <b>4/9/59 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. (City or town) (County) (State) <b>Colesville Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>April 9, 1959</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond W. Piska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>APR 13 59</b> DATE	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
42003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		DATE OF DEATH [REDACTED]	
AGE [REDACTED]		SEX [REDACTED]	
RACE [REDACTED]		EDUCATION [REDACTED]	
OCCUPATION [REDACTED]		RESIDENCE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]	
MANNER OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
DISEASE OR INJURY [REDACTED]		TREATMENT [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		DATE [REDACTED]	
OFFICE OF THE MEDICAL EXAMINER [REDACTED]		COUNTY [REDACTED]	



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4510  
CERTIFICATE OF DEATH

04477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>78 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>11 West Irving Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Eastburne</b> Last <b>Chase</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 18, 1901</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School Teaching</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Adolph Mattern</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMATION <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolus</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Right Femoral Thrombophlebitis</b> DUE TO <b>Metastatic Carcinoma of Breast</b> (c) <b>8 wks.</b> <b>15 mos.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 12, 1959</b> to <b>April 7, 1959</b> , that I last saw the deceased alive on <b>April 7, 1959</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-7-59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Donald A. Kellogg</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Donald A. Kellogg, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 9 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4511

CERTIFICATE OF DEATH

04478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write name of town and give nearest town) <b>West Kensington</b> c. LENGTH OF STAY IN 1b <b>West Kensington</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3316 University Blvd.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Kensington</b> d. STREET ADDRESS <b>3316 University Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>David</b> Last <b>Clark</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/1/65</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min.		11. IF UNDER 24 HRS. Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min.		12. IF UNDER 24 HRS. Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clergyman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William Clark</b>			
14. MOTHER'S MAIDEN NAME <b>Rebecca DeRille</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>Rev. Edward O. Clark</b>				17. ADDRESS <b>3708 Livingston St. N.W. Wash., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO <b>5 days</b> (c) <b>5 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>Apr 8</b> , 19 <b>59</b> , to <b>April 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 14</b> , 19 <b>59</b> , and that death occurred at <b>11:45 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D. <b>10609 Concord Street</b>				DATE SIGNED <b>Apr 16, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D. Kensington, Md.</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			
22b. DATE THEREOF <b>4/20/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Northwood Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</b>			
24a. REC'D BY REGISTRAR <b>APR 20 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

10-13-54

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04479  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>California</b> d. STREET ADDRESS <b>RR</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sunshine</b> Middle <b>(none)</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-27-27</b>
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months <b>18</b>	IF UNDER 24 HRS. Days <b>2</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elling JOHANNESSEN</b>		14. MOTHER'S MAIDEN NAME <b>Lilly (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>	
17. INFORMANT <b>(H) Jack Clark, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema and contusion</b> <b>816 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Injuries sustained in automobile accident</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of pelvis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was passenger in car driven by husband involved in two car accident, thrown from car to highway and struck by third vehicle.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>6:45</b> p.m. <b>3-26</b> 19 <b>59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway- Rt. 235</b>	20f. (City or town) (County) (State) <b>Chancellor Run Rd. St. Marys Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>4-4-59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 7, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church of the Nazarene</b>	22d. LOCATION (City, town, or county) (State) <b>California Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mattingly Funeral Home, Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 8 '59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Death: \_\_\_\_\_

5. Place of Death: \_\_\_\_\_

6. Cause of Death: \_\_\_\_\_

7. Manner of Death: \_\_\_\_\_

8. Signature of Medical Examiner: \_\_\_\_\_

9. Signature of Coroner: \_\_\_\_\_

10. Signature of Registrar: \_\_\_\_\_

11. Signature of Physician: \_\_\_\_\_

12. Signature of Nurse: \_\_\_\_\_

13. Signature of Pathologist: \_\_\_\_\_

14. Signature of Forensic Scientist: \_\_\_\_\_

15. Signature of Toxicologist: \_\_\_\_\_

16. Signature of Anthropologist: \_\_\_\_\_

17. Signature of Entomologist: \_\_\_\_\_

18. Signature of Botanist: \_\_\_\_\_

19. Signature of Zoologist: \_\_\_\_\_

20. Signature of Geologist: \_\_\_\_\_

21. Signature of Meteorologist: \_\_\_\_\_

22. Signature of Astronomer: \_\_\_\_\_

23. Signature of Chemist: \_\_\_\_\_

24. Signature of Physicist: \_\_\_\_\_

25. Signature of Engineer: \_\_\_\_\_

26. Signature of Architect: \_\_\_\_\_

27. Signature of Lawyer: \_\_\_\_\_

28. Signature of Judge: \_\_\_\_\_

29. Signature of Minister: \_\_\_\_\_

30. Signature of Priest: \_\_\_\_\_

31. Signature of Rabbi: \_\_\_\_\_

32. Signature of Imam: \_\_\_\_\_

33. Signature of Buddhist: \_\_\_\_\_

34. Signature of Hindu: \_\_\_\_\_

35. Signature of Jain: \_\_\_\_\_

36. Signature of Sikh: \_\_\_\_\_

37. Signature of Muslim: \_\_\_\_\_

38. Signature of Christian: \_\_\_\_\_

39. Signature of Jew: \_\_\_\_\_

40. Signature of Other: \_\_\_\_\_



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4513 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>			
c. LENGTH OF STAY IN 1b <u>EOA</u>				d. STREET ADDRESS <u>Ridge Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In Gordon Smith's office</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leonard Lee Cole</u>				4. DATE OF DEATH <u>Apr 9 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-6-59</u>	
9. AGE (in years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <u>John S. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Whitworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John S. Cole (father)</u> Address <u>Itin 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Asphy. Aspiration of vomitus</u> DUE TO (c) <u>upper Respir Infection</u> INTERVAL BETWEEN ONSET AND DEATH <u>Some collapsed in bed</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-11-59</u>		<u>Presbyterian Cem</u>		<u>Boyd, Monty, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.B. Hilton, Barnesville, md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

2074295xv4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4468

CERTIFICATE OF DEATH

04481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EVENTIDE NURSING HOME</u> <u>700 HUDSON AVENUE</u>		d. STREET ADDRESS <u>CLIPTON TERRACE APTS.</u> <u>1412 + CLIPTON STS. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>HEATH</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11, 1871</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HEATH</u>		14. MOTHER'S MAIDEN NAME <u>ANN -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MRS. WOODROW W. WHITE</u>		Address <u>ROUTE 3 BOX 525</u> <u>CLINTON, M.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>176.1</u> <u>carcinoma of the Vagina</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>22 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>April 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>59</u> , and that death occurred at <u>9:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil P. Campbell</u>		DATE SIGNED <u>4/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>		ADDRESS (Street, city or town, state) <u>3060-16th St Wash D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		24a. RECD BY REGISTRAR <u>APR 13 1959</u>	
ADDRESS <u>3821-14th St. N.W. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

CERTIFICATE OF DEATH

See Ord. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		45		1890		Baltimore, Md.		Carpenter		Heart Disease		Home		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH		17. PLACE OF DEATH		18. TIME OF DEATH		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF WITNESSES		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF WITNESSES	
1890		10:30 AM		Home		Heart Disease		Home		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
15. PLACE OF DEATH		16. CAUSE OF DEATH		17. PLACE OF DEATH		18. TIME OF DEATH		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF WITNESSES		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF WITNESSES		25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF PHYSICIAN	
Home		Heart Disease		Home		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF PHYSICIAN		21. SIGNATURE OF WITNESSES		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF WITNESSES		25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF WITNESSES	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF WITNESSES		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF PHYSICIAN		33. SIGNATURE OF WITNESSES		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF WITNESSES		37. SIGNATURE OF REGISTRAR		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF WITNESSES		40. SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH—BALTIMORE 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

4514

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>6 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>9605 SINGLETON DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>Phillip</u> Last <u>JR.</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/24/19</u>	
9. AGE (In years lost birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>8</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ADMIRAL DISTRIBUTORS CONN.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>THOMAS PHILLIP CORCORAN SR.</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BRADA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1938-1942</u>				16. SOCIAL SECURITY NO. <u>MRS. MARY C. CORCORAN</u>			
17. INFORMANT <u>MRS. MARY C. CORCORAN</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction —</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease ?</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>April 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3605 10511 Summit Ave</u> DATE SIGNED <u>4/8/59</u> ACTUAL SIGNATURE <u>Horace W. Bernton</u> M.D. <u>3605 10511 Summit Ave</u> PHYSICIAN'S NAME (Type) <u>HORACE W. BERNTON</u> <u>Kennington, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-10-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>			
ADDRESS <u>Bethesda, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





4515

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KENSINGTON</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KENSINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ida</b> <b>M.</b> <b>Cross</b>		4. DATE OF DEATH <b>April</b> <b>25</b> <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 2, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MANUFACTURING</b>	
11. BIRTHPLACE (State or foreign country) <b>PETERSBURG, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY R. RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>CAMPBELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS JULIAN COTTRELL</b>		Address <b>KENSINGTON, 10601 NASH PL.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia, Somatic exhaustion</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis, Primary, Breast</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>5 Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1956</b> , 19 <b>Apr 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Apr 25</b> , 19 <b>59</b> , and that death occurred at <b>12:30 P.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		ADDRESS (Street, city or town, state) <b>10609 Concord Street Kensington, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>R</b>		DATE SIGNED <b>Apr 25, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>4/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGES Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert T. Thibadeau</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haud</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4516

## CERTIFICATE OF DEATH

04484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN TB <u>12 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. STREET ADDRESS <u>1538 Anderson Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>CULLOP</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/59</u>
9. AGE (In years last birthday) <u>N.B.</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH C. CULLOP</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR C. SEYMOUR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father Joseph C. Cullop</u>		Address <u>538 Anderson Ave Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO <u>Apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary atelectasis</u> DUE TO (c) <u>Interstitial emphysema - Mediastinum</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL 16, 1959</u> to <u>APRIL 17, 1959</u> , that I last saw the deceased alive on <u>APRIL 17, 1959</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ira W. Pearlman</u> M.D.		ADDRESS (Street, city or town, state) <u>4700 Bradley Blvd. Chevy Chase, Maryland</u>	
DATE SIGNED <u>4-17-59</u>			
PHYSICIAN'S NAME (Type) <u>IRA W. PEARLMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. PLACE OF DEATH Home	
9. CAUSE OF DEATH Heart Disease		10. MEDICAL HISTORY None	
11. SIGNATURE OF PHYSICIAN J. J. Smith		12. SIGNATURE OF DECEASED None	
13. SIGNATURE OF WITNESSES J. J. Smith		14. SIGNATURE OF DECEASED None	
15. SIGNATURE OF DECEASED None		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF DECEASED None		18. SIGNATURE OF DECEASED None	
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1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. PLACE OF DEATH  
9. CAUSE OF DEATH  
10. MEDICAL HISTORY  
11. SIGNATURE OF PHYSICIAN  
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4517

# CERTIFICATE OF DEATH

04485

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>		c. LENGTH OF STAY IN Ib <b>5 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring, Md.</b>		d. STREET ADDRESS <b>9103 Linton St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9103 Linton St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Homer H. Cummings</b>		4. DATE OF DEATH Month <b>April</b> , Day <b>21</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1880</b>
9. AGE (In years last birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ordance Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Homer Hamilton Cummings</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Cowden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>No</b>	
17. INFORMANT <b>Rosa K. Cummings-wife</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic myocardiosis</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio-sclerotic vascular renal failure 4 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1945</b> , to <b>April 21, 1959</b> , that I lost saw the deceased olive on <b>April 21, 1959</b> , and that death occurred at <b>7<sup>30</sup> P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Frank R. Shea</b> M.D. <b>4100 - 22nd St. N.E. Wash DC 4/21/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>FRANK R. SHEA, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE		22f. REC'D BY REGISTRAR	
22g. ADDRESS		22h. REGISTRAR'S SIGNATURE	
22i. DATE		22j. SIGNATURE	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57





4518

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>5 mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Frances Cummings</b>		4. DATE OF DEATH Month Day Year <b>April 12 19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/1866</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Day</b>		14. MOTHER'S MAIDEN NAME <b>Claggett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nursing Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of rt. hip 3/26/59</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-13-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Leitchfield, Kentucky</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4469

## CERTIFICATE OF DEATH

Reg. Dist. No.

04487

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>10 mo.</u>		d. STREET ADDRESS <u>311 Whittier St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eventide</u> <u>700 Hudson</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>Davis</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Nake</u>		14. MOTHER'S MAIDEN NAME <u>Julia Hassendeubel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Thomas M. Davis (husband) 311 Whittier Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-17-</u> 19 <u>58</u> , to <u>Apr 21</u> 19 <u>59</u> , that I last saw the deceased alive on <u>April 14</u> 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>2201 Canal Ave</u> DATE SIGNED <u>4-20-59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK, M.D.</u>		<u>Takoma Park 12 mo</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSOING COMPANY INC. 1300 N. STREET N.W. WASHINGTON, D.C.</u>		24a. REC'D BY REGISTRAR <u>APR 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1918

NAME OF DECEASED [Illegible]		SEX Male	
AGE 10		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		COLOR White	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF MINISTER [Illegible]	
NAME OF BURIAL PLACE [Illegible]		NAME OF CEMETERY [Illegible]	
NAME OF INTERVIEWER [Illegible]		NAME OF REGISTRAR [Illegible]	
NAME OF CLERK [Illegible]		NAME OF ASSISTANT CLERK [Illegible]	

1/23/22

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4519**  
**CERTIFICATE OF DEATH**

04488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLNEY</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen L. Davison</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ART ILLUSTRATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	9. AGE (In years last birthday) <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas. E. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Edith H. Smart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-46-3599B</u>	
17. INFORMANT <u>Philip Davison</u>		Address <u>4740 Bradley Blvd Chevy Chase Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. truo Sclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma left breast</u> DUE TO (c) <u>with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/10/</u> , 19 <u>59</u> , to <u>4/15/</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/14/</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Sp...</u> <u>md 4/15/59</u>	
PHYSICIAN'S NAME (Type) <u>J. W. BIRD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond L. Fisher</u>		ADDRESS <u>4334 Ga. Ave. Md.</u>	24a. REC'D BY REGISTRAR <u>APR 17 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. CAUSE OF DEATH: \_\_\_\_\_

8. PLACE OF DEATH: \_\_\_\_\_

9. DATE OF DEATH: \_\_\_\_\_

10. TIME OF DEATH: \_\_\_\_\_

11. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

12. SIGNATURE OF REGISTRAR: \_\_\_\_\_

13. SIGNATURE OF WITNESS: \_\_\_\_\_

14. SIGNATURE OF DECEASED: \_\_\_\_\_

15. SIGNATURE OF NEXT OF KIN: \_\_\_\_\_

16. SIGNATURE OF BURIAL OFFICIAL: \_\_\_\_\_

17. SIGNATURE OF CHURCH OFFICIAL: \_\_\_\_\_

18. SIGNATURE OF FUNERAL HOME: \_\_\_\_\_

19. SIGNATURE OF CEMETERY: \_\_\_\_\_

20. SIGNATURE OF OTHER: \_\_\_\_\_



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4520

CERTIFICATE OF DEATH

04489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens</b>				d. STREET ADDRESS <b>6815 Brookville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>E</b> Last <b>DeVEAU</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1874</b>		9. AGE (In years last birthday) yrs <b>85</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>0</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Theodore Burlet</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Donald E. DeVeau, 4100 Jones Bridge Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, general, severe</b> DUE TO (c) <b>Hypertension, severe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>5 yrs +</b> <b>5 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> to <b>April 21, 1959</b> , that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D. <b>3921 Ingomar St</b>				ADDRESS (Street, city or town, state) <b>Wash 15 DC</b> DATE SIGNED <b>April 21 '59</b>			
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 23 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4521

CERTIFICATE OF DEATH

04490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5404 EDMOND LANE</u>			
d. STREET ADDRESS <u>5404 EDMOND LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FANNY</u> Middle <u>SINGER</u> Last <u>DOCTER</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>	
9. AGE (In years last birthday) <u>80?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>/</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN SINGER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARION D. FRIEND</u> Address <u>BETHESDA, MD. 5404 EDMOND LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>10 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>59</u> , and that death occurred at <u>U.P.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jerome J. Krick</u>				ADDRESS (Street, city or town, state) <u>2800 Duke St. N.W.</u> DATE SIGNED <u>4/22/59</u>			
PHYSICIAN'S NAME (Type) <u>TEROME J. KRICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>4-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki Sons</u> ADDRESS <u>1756 Pa. Ave N.W.</u>				24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

## MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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## CERTIFICATE OF DEATH

04491

Reg. Dist. No.

4522

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>37 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1913 GRACE CHURCH ROAD</b>		e. STREET ADDRESS <b>1913 GRACE CHURCH ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>LEO</b> Last <b>DONALDSON, SR.</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 19, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile painter (retired) Auto Garage</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Donaldson</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-14-0272</b>	
17. INFORMANT <b>Mrs. Martina H. Donaldson, 1913 Grace Church Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19, 1958</b> to <b>Apr. 5, 1959</b> , that I last saw the deceased alive on <b>Feb. 26, 1959</b> , and that death occurred at <b>8:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9241 Col. Blvd.</b> DATE SIGNED <b>4/8/59</b>			
ACTUAL SIGNATURE <b>Marion Bonkhead M.D.</b>		PHYSICIAN'S NAME (Type) <b>J. Marion Bonkhead Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>Raymond A. Ziska</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4523

Item 9 Film G241 5-1-59 et

CERTIFICATE OF DEATH

04492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>		d. STREET ADDRESS <u>3222 Terrace Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Hughes</u> Middle <u>M.</u> Last <u>Eagan</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 18 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM DE GRIFF</u>		14. MOTHER'S MAIDEN NAME <u>AGNES MacNEIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>71's Hosp. Record</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO <u>Acute Parotitis Right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>16 days</u> (c) <u>10 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 26</u> , 19 <u>59</u> , to <u>Apr 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>59</u> , and that death occurred at <u>11:25</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. W. Bird</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/11/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. W. Bird</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>4/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>1661 Good Hope</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

CERTIFICATE OF DEATH

(1353)

1. NAME OF DECEASED <i>WILLIAM DEWEY</i>		2. SEX <i>Male</i>		3. AGE <i>62</i>	
4. DATE OF BIRTH <i>1881</i>		5. PLACE OF BIRTH <i>MASSACHUSETTS</i>		6. OCCUPATION <i>None</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1908</i>		9. PLACE OF MARRIAGE <i>MASSACHUSETTS</i>	
10. NAME OF SPouse <i>Elizabeth</i>		11. DATE OF DEATH <i>1943</i>		12. PLACE OF DEATH <i>MASSACHUSETTS</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL <i>None</i>	
16. SIGNATURE OF DECEASED <i>None</i>		17. SIGNATURE OF SPouse <i>None</i>		18. SIGNATURE OF WITNESS <i>None</i>	
19. SIGNATURE OF PHYSICIAN <i>None</i>		20. SIGNATURE OF CLERK <i>None</i>		21. SIGNATURE OF REGISTRAR <i>None</i>	

APPROVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU 18  
1000 STATE STREET, BOSTON, MASSACHUSETTS  
1943

## 04493

FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH  
 1901

PLACE OF DEATH  
 HOME

AGE OF DECEASED  
 45

SEX  
 MALE

CAUSE OF DEATH  
 HEART DISEASE

2011-1901

1901-1901

YES

1901-1901

CAUSE OF DEATH  
 HEART DISEASE

1901-1901

1901-1901

1901-1901

1901-1901

1901-1901

1901-1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4524

## CERTIFICATE OF DEATH

04494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>410 TARRINGTON PLACE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELIZABETH</b> Last <b>ELLIOTT</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/21/73</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>MICHAEL JENNINGS</b>				14. MOTHER'S MAIDEN NAME <b>CECELIA DENNIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mr. George Elliott, 410 Tarrington Place</b> <b>Silver Spring, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary heart disease</b> DUE TO (c) <b>Coronary heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>59</b> , to <b>April 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>59</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>12020 Georgia Ave., Silver Spring, Md.</b> DATE SIGNED <b>4/14/59</b>							
ACTUAL SIGNATURE <b>Patrick Jameson, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>PATRICK JAMESON, JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>							
ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR <b>APR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

CERTIFICATE OF DEATH

1934

1. NAME OF DECEASED WILLIAM H. BILLYOT		2. SEX Male		3. AGE 47		4. DATE OF BIRTH 1887	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. PLACE OF DEATH BALTIMORE, MARYLAND		10. DATE OF DEATH MAY 15, 1934		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF PHYSICIAN J. H. BILLYOT	
13. SIGNATURE OF REGISTRAR J. H. BILLYOT		14. SIGNATURE OF WITNESSES J. H. BILLYOT		15. SIGNATURE OF CLERK J. H. BILLYOT		16. SIGNATURE OF DECEASED J. H. BILLYOT	

MADE IN U.S.A.





1944

UNITED STATES DEPARTMENT OF AGRICULTURE

WASH.

OFFICE OF THE  
DIRECTOR  
OF THE  
BUREAU OF  
PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE  
DIRECTOR  
OF THE  
BUREAU OF  
PLANT INDUSTRY  
WASHINGTON, D. C.

FROM  
[Illegible Name]  
[Illegible Title]  
[Illegible Address]

SUBJECT  
[Illegible Subject]

[Illegible Body Text]

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4526**  
**CERTIFICATE OF DEATH**

04496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>Kensington</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Soldiers Sanitarium</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <del>Max XXXX</del> <u>ANNA MELISSA</u> <u>Ewell</u>			4. DATE OF DEATH <u>4</u> / <u>8</u> / <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1866</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>ABEL JARRETT</u>			14. MOTHER'S MAIDEN NAME <u>JERUSIO DUNN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>Mrs. T. Lee Langford, 1204 Burton St. Silver Spring, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE, PERIPHERAL</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CACCELEXIA.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>2 WKS.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>MAY, 1957</u> to <u>8 APR.</u> , 1959, that I last saw the deceased alive on <u>8 APR.</u> , 1959, and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Marshall Cuvillier Jr.</u>			ADDRESS (Street, city or town, state) <u>1407 Woodside Pkwy. Silver Spring, Md.</u>		
PHYSICIAN'S NAME (Type) <u>L. Marshall Cuvillier</u>			DATE SIGNED <u>8 APR. 59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elliotts Island Church Cemetery, Elliotts Island, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



21  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4527  
CERTIFICATE OF DEATH

04497  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>3513 Raymoor Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>E.</b> Last <b>Fairbank</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/63</b>		9. AGE (In years last birthday) <b>95</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walters</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miriam Stopsack</b>		Address <b>3513 Raymoor Road Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia, rt., severe with aphasia</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, severe</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> , to <b>April 15, 1959</b> , that I last saw the deceased alive on <b>April 14, 1959</b> , and that death occurred at <b>1054 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3921 Ingomar St. Wash 15 DC</b> DATE SIGNED <b>4/15/59</b>							
ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D.				PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>	
<p>3. AGE                  _____</p>		<p>4. DATE OF BIRTH                  _____</p>	
<p>5. PLACE OF BIRTH                  _____</p>		<p>6. OCCUPATION                  _____</p>	
<p>7. MARITAL STATUS                  _____</p>		<p>8. COLOR OF HAIR                  _____</p>	
<p>9. COLOR OF EYES                  _____</p>		<p>10. COLOR OF SKIN                  _____</p>	
<p>11. CAUSE OF DEATH                  _____</p>		<p>12. PLACE OF DEATH                  _____</p>	
<p>13. DATE OF DEATH                  _____</p>		<p>14. TIME OF DEATH                  _____</p>	
<p>15. SIGNATURE OF DECEASED                  _____</p>		<p>16. SIGNATURE OF WITNESS                  _____</p>	
<p>17. SIGNATURE OF PHYSICIAN                  _____</p>		<p>18. SIGNATURE OF CORONER                  _____</p>	
<p>19. SIGNATURE OF JURY                  _____</p>		<p>20. SIGNATURE OF JUDGE                  _____</p>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4528 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04498  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>	c. LENGTH OF STAY IN 1b <b>14 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6506 78th St.</b>		d. STREET ADDRESS <b>6506 78th St</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Daniel Maxton Farrell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/25/1911</b>
9. AGE (In years last birthday) <b>48 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Instrument maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>David Taylor Model Basin N.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rufus Farrell</b>		14. MOTHER'S MAIDEN NAME <b>Dahlia Lilly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Margaret M. Farrell (wife)</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertention</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>20 mins.</b> years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		DATE SIGNED <b>April 29, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans.</b>		22b. DATE THEREOF <b>5-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hanks Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsboro, North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>		24e. REC'D BY REGISTRAR DATE <b>MAY 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

STAY 2004  
TUESDAY 10:30AM

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4529

## CERTIFICATE OF DEATH

04499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3915 BALTIMORE STREET</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KENSINGTON</b> d. STREET ADDRESS <b>3915 BALTIMORE STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD A. FARRELL</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 5, 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT (R.F.C.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. GOVERNMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>BROOKLYN, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>EDWARD FARRELL</b>		14. MOTHER'S MAIDEN NAME <b>JULIETTE HOUTAIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW #1</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>JUSTIN E. FARRELL, 3915 BALTO. ST., KENSINGTON, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Cholesterol</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1958</b> , to <b>April 24, 1959</b> , that I last saw the deceased alive on <b>April 23, 1959</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above. <b>10511</b> ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>George Sharpe</b> M.D. <b>XXXXX SUMMIT AVE., KENSINGTON, MD. 4/24/59</b> PHYSICIAN'S NAME (Type) <b>GEORGE SHARPE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE'S COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Anthony J. Hanna</b>			

*Myocardial Infarction*  
*Coronary Artery Disease*

*George J. [unclear]*  
22 April 24  
22 April 24

4530

## CERTIFICATE OF DEATH

04500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 dys 10½ hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. STREET ADDRESS <b>6644 Hilldale Road</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FIGGINS,</b> Middle <b>Charles W.</b> Last				4. DATE OF DEATH Month <b>4</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/13/1882</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Goes Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles Edward Figgins</b>				14. MOTHER'S MAIDEN NAME <b>Katherine E. Derrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>015-10-5230A</b>		17. INFORMANT Address <b>son (Mr. Weston Figgins)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Thrombosis &amp; multiple pulmonary emboli</b> DUE TO <b>infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>420.0</b> (b) <b>Mural Thrombosis of the rt. auricle.</b> DUE TO <b>Arteriosclerotic heart disease &amp; myocardial infarction</b> (c) <b>Arteriosclerotic heart disease &amp; myocardial infarction</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1959</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> , to <b>April 9, 1959</b> , that I last saw the deceased alive on <b>April 8, 1959</b> , and that death occurred at <b>12:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stewart Clapp</b>				ADDRESS (Street, city or town, state) <b>3921 Ingomar St NW Wash 15 D.C.</b>			
DATE SIGNED <b>4-9-59</b>							
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 4531 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04501

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1121 Belvidere Blvd.</u>			d. STREET ADDRESS <u>1121 Belvidere Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Benjamin Fine</u>			4. DATE OF DEATH Month <u>Apr</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1891</u>		9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Abraham Max Fine</u>		14. MOTHER'S MAIDEN NAME <u>Russie Fine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-107456</u>		17. INFORMANT <u>Max Cook (son)</u> Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hanging</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck in basement of his home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-6-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Phila Pa</u>	
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Houns</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash DC</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on a medical certificate form. The form includes sections for patient information, cause of death, and examiner details. Some legible fragments include:]*

*[Top Section: Patient Information]*  
Name: *[illegible]*  
Age: *[illegible]*  
Sex: *[illegible]*  
Race: *[illegible]*  
Occupation: *[illegible]*  
Residence: *[illegible]*

*[Middle Section: Cause of Death]*  
Cause of Death: *[illegible]*  
Manner of Death: *[illegible]*  
Place of Death: *[illegible]*

*[Bottom Section: Examiner Information]*  
Examiner: *[illegible]*  
Signature: *[illegible]*  
Date: *[illegible]*

*[Checkboxes and other markings are visible but not legible.]*

4532

CERTIFICATE OF DEATH

04502

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>1530 North Lancaster Street</u>	
3. NAME OF DECEASED (Type or print) First <u>FINEGAN</u> Middle <u>BARBY</u> Last <u>BOY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-59</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT J. FINEGAN JR.</u>		14. MOTHER'S MAIDEN NAME <u>Shirley NEDELOW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ROBERT J. FINEGAN (father)</u>	
17. INFORMANT <u>ROBERT J. FINEGAN (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 17, 1959</u> , to <u>April 17, 1959</u> , that I last saw the deceased alive on <u>April 17, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Ross M. Wilson</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Seasons Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

2074 222 x VI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 15, 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. PHYSICIAN'S SIGNATURE <i>Dr. J. H. Smith</i>		17. COUNTY <i>Baltimore</i>		18. CITY <i>Baltimore</i>	
19. STATE <i>Md.</i>		20. ZIP CODE <i>21201</i>		21. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	
22. DATE OF REGISTRATION <i>April 16, 1933</i>		23. TIME OF REGISTRATION <i>11:00 AM</i>		24. PLACE OF REGISTRATION <i>Health Department</i>	



THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE FILES OF THE DEPARTMENT. IT IS NOT TO BE LOANED OR GIVEN TO ANY OTHER PERSON. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE FILES OF THE DEPARTMENT. IT IS NOT TO BE LOANED OR GIVEN TO ANY OTHER PERSON. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER.

4533

CERTIFICATE OF DEATH

04503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>1534 CALVIN LANE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES BRADLEY FIRTH</u>				4. DATE OF DEATH Month Day Year <u>4 17 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-21-23</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>8 26</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUS. SECRETARY CENTRAL YMCA</u>		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>FRANK L. FIRTH</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL BRADLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or date of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>017-16-481</u>		17. INFORMANT Address <u>534 CALVIN LA. VIRGINIA FIRTH (WIFE) ROCKVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of large bowel</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>approx 3 mo.</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-11</u> , 19 <u>56</u> , to <u>4-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-17</u> , 19 <u>59</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Hall</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>65 W. Montgomery Ave. Rockville, Md. 4-18-59</u>			
M.D. <u>W. G. Hall</u>							
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>				615 W. Montg. Ave. Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4534

## CERTIFICATE OF DEATH

04504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>718 BRENT ROAD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE 26</b> d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BEVERLY SUE FITZWATER</b>		4. DATE OF DEATH Month Day Year <b>APRIL 3 19 59</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/56</b>		9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HERMAN HOMER FITZWATER</b>		14. MOTHER'S MAIDEN NAME <b>FERN LUCILLE MOBLEY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest during anesthesia</b> DUE TO <b>induction on 4/2/59 - cause unknown.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>induction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>22 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 30, 1959</b> , to <b>April 3, 1959</b> , that I last saw the deceased alive on <b>April 3, 1959</b> , and that death occurred at <b>7:45A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Rockville, Maryland</b>		DATE SIGNED <b>4/3/59</b>		ACTUAL SIGNATURE <b>Arthur F. Woodward</b> M.D.	
PHYSICIAN'S NAME (Type) <b>A. F. WOODWARD, M. D.</b>		Rockville, Maryland		22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REG. BY REGISTRAR <b>APR 7 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05745

4470

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		c. LENGTH OF STAY IN 1b <b>56 Silver Spring,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		d. STREET ADDRESS <b>1551 N. Falkland Lane,</b>	
3. NAME OF DECEASED (Type or print) <b>James Michael Flickinger</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1959</b> <b>April 17, 1959</b>
9. AGE (In years last birthday) yrs. <b>3 1/2</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Edward LaVerne Flickinger</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Althea Swank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>father</b>	
17. INFORMANT <b>same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>753.1 Congenital Cystic Degeneration of the brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>21 days</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 27, 1959</b> , to <b>April 17, 1959</b> , that I last saw the deceased alive on <b>April 16, 1959</b> , and that death occurred at <b>7:30 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sydney Leventhal</b>		ADDRESS (Street, city or town, state) <b>9210 Colesville Rd., Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M. D.</b>		DATE SIGNED <b>4/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		ADDRESS <b>Washington Sanitarium and Hosp., Takoma Park, Maryland</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

MAY 12 '59

Arthur S. Hare

# CERTIFICATE OF DEATH

1920

1920

MARYLAND STATE DEPARTMENT OF HEALTH - EASTERN ONE 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1875		BALTIMORE, MD.	
MARRIED		WIFE		NAME		AGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
YES		MARY H. HARRIS		35		W		JUN 10 1905		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		HOUR OF DEATH		MINUTES OF DEATH	
HEART DISEASE		NATURAL		HOME		JUN 10 1920		10:30		10:30	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
TUBERCULOSIS		NATURAL		HOSPITAL		JUN 10 1920		11:00		11:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
PNEUMONIA		NATURAL		HOSPITAL		JUN 10 1920		12:00		12:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
INFLUENZA		NATURAL		HOSPITAL		JUN 10 1920		13:00		13:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
SCARLET FEVER		NATURAL		HOSPITAL		JUN 10 1920		14:00		14:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DIPHTHERIA		NATURAL		HOSPITAL		JUN 10 1920		15:00		15:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
TYPHOID FEVER		NATURAL		HOSPITAL		JUN 10 1920		16:00		16:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
MALARIA		NATURAL		HOSPITAL		JUN 10 1920		17:00		17:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
SYPHILIS		NATURAL		HOSPITAL		JUN 10 1920		18:00		18:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
GONORRHOEA		NATURAL		HOSPITAL		JUN 10 1920		19:00		19:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
CHOLERA		NATURAL		HOSPITAL		JUN 10 1920		20:00		20:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
TYPHOUS FEVER		NATURAL		HOSPITAL		JUN 10 1920		21:00		21:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSENTERY		NATURAL		HOSPITAL		JUN 10 1920		22:00		22:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
SCURVY		NATURAL		HOSPITAL		JUN 10 1920		23:00		23:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
RICKETS		NATURAL		HOSPITAL		JUN 10 1920		24:00		24:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
BERBERIUS		NATURAL		HOSPITAL		JUN 10 1920		25:00		25:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
TETANUS		NATURAL		HOSPITAL		JUN 10 1920		26:00		26:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
EPISTEMORRHOEA		NATURAL		HOSPITAL		JUN 10 1920		27:00		27:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
HÆMORRHOIDAL AGUE		NATURAL		HOSPITAL		JUN 10 1920		28:00		28:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
TYPHOID		NATURAL		HOSPITAL		JUN 10 1920		29:00		29:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		30:00		30:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		31:00		31:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		32:00		32:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		33:00		33:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		34:00		34:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		35:00		35:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		36:00		36:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		37:00		37:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		38:00		38:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		39:00		39:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		40:00		40:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		41:00		41:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		42:00		42:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		43:00		43:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		44:00		44:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		45:00		45:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		46:00		46:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		47:00		47:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		48:00		48:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		49:00		49:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		50:00		50:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		51:00		51:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		52:00		52:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		53:00		53:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		54:00		54:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		55:00		55:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		56:00		56:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		57:00		57:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		58:00		58:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		59:00		59:00	
DISEASE		MANNER		PLACE		DATE		HOUR		MINUTES	
DYSPEPSIA		NATURAL		HOSPITAL		JUN 10 1920		60:00		60:00	

1920

CERTIFICATE OF DEATH

04505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>X</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10308 Kensington Parkway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10308 Kensington Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY MARVIN FLINN</b>		4. DATE OF DEATH Month Day Year <b>April 8 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1882</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1 19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Howard Flinn</b>		14. MOTHER'S MAIDEN NAME <b>Ada Berry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-32-1709</b>	
17. INFORMANT <b>Nannie E. Flinn-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 7</b> , 19 <b>52</b> , to <b>present</b> , 19 <b>59</b> , that I lost saw the deceased alive on <b>about April 1</b> , 19 <b>59</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>George Sharpe</b> M.D. <b>10511 Summit Ave</b> <b>4/8/59</b> PHYSICIAN'S NAME (Type) <b>George Sharpe</b> <b>Kensington, Md</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4533

CENTRAL AVE OF DEATH

Washington, D.C. 20001

Washington

Washington

1000 Kensington Parkway

1000 Kensington Parkway

LIBRARY MARVIN ELIN

Male White Pop. 10, 1988 77 1 10

Virginia Religion

Age 18

Howard Elton

212-31-1700 Sample 1, 1988-1-1

No

British 110/00

Report A. 1 ungrouped-1988-1-1



**4536**

**CERTIFICATE OF DEATH**

**04506**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>4 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1740 Takoma Park</u> d. STREET ADDRESS <u>405 Lincoln Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Simon Cirrmeno Forinas</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>April 12 1959</u>							
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 3, 1892</u>		<b>9. AGE</b> (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Curator</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Smithsonian Institution</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Philippine Is.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Gregoria Forinas</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Veronica C. Cirrmeno</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1917-18</u>				<b>16. SOCIAL SECURITY NO.</b> <u>115</u>		<b>17. INFORMANT</b> Address <u>Mrs. Rosa Forinas -</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>42 HOURS</u> <u>OVER 3 YEARS</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
<b>21. I certify that I attended the deceased from</b> <u>April 12</u> , 19 <u>59</u> , to <u>April 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>59</u> , and that death occurred at <u>3:35</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9420 Washington Road</u> DATE SIGNED <u>April 12 1959</u> ACTUAL SIGNATURE <u>Joseph V. Connor, M.D.</u> PHYSICIAN'S NAME (Type) <u>JOSEPH V. CONNOR</u> <u>Bethesda 14, Maryland</u>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>April 15, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Washington, Virginia</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>254 CARROLL ST. N.W. WASH. D.C.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 14 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
HASTLAND		APRIL 12, 1959	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
AGE		SEX	
65		M	
RACE		RELIGION	
WHITE		METHODIST	
OCCUPATION		CAUSE OF DEATH	
RETIRED		CORONARY THROMBOSIS	
PREVIOUS ILLNESS		IMMEDIATE CAUSE OF DEATH	
NONE		CORONARY THROMBOSIS	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
APRIL 12, 1959		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF EXAMINER	
[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 12, 1959		APRIL 12, 1959	

4/12/59 Dr. J. J. Brackhart, Rep. Med. Examiner notified and  
 approved certificate to be signed by Dr. J. W. Connor.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04507

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		d. STREET ADDRESS <u>122 C. ST. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter Preston Fowler</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-72</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Walter Preston Fowler Sr.</u>				14. MOTHER'S M maiden NAME <u>Elma Comora Filler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT (Daughter) <u>Louisa May McTeel</u>		Address <u>Hyattsville Ind 2406 Cherokee ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-8-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-11-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HANLON FUNERAL HOME</u>				ADDRESS <u>3831-GR Ave</u>		24a. REC'D BY REGISTRAR <u>APR 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

MEDICAL CERTIFICATION

2

SP



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4537** Item 22 Film G241 4-29-59 et  
**CERTIFICATE OF DEATH**

04508

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney, Md.</b> c. LENGTH OF STAY IN 1b <b>1 Yr. 7 Mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brooke Grove Chronic Hosp.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <span style="float: right;">47X-3</span> d. STREET ADDRESS <b>3915 Military Rd., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>HORACE</b> Middle <b>T.</b> Last <b>FRIES</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>12</b> Year <b>19 59</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct., 25, 1881</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Accountant</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Phil. Pa.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>?</b> <b>Fries</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Earl Riddles</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>3915 Military Rd., N.W.</b> <b>Mrs. Kenneth Croft Washington, D.C.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Apoplexy, Hemorrhagic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) <b>Cerebrovascular arterio sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>5 yrs.</b> <b>10 yrs.</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I attended the deceased from Jan 1958, to April 12, 1959, that I last saw the deceased alive on April 11, 1959, and that death occurred at M, from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) DATE SIGNED											
<b>ACTUAL SIGNATURE</b> <b>A. D. Bonifant</b> M.D. <b>Sandy Spring, Md 4/12/59</b> <b>PHYSICIAN'S NAME (Type)</b> <b>A. D. BONIFANT</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>22b. DATE THEREOF</b> <b>4/14/59</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln Cem</b>				<b>22d. LOCATION (City, town, or county)</b> (State) <b>Bladensburg Rd Md</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Chevy Chase Funeral Home, 5103 Wisc. Ave., D.C.</b>						<b>24a. REC'D BY REGISTRAR</b> DATE <b>APR 16 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04509

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>		c. LENGTH OF STAY IN lb <u>29 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6112 McArthur Blvd - Wash 16-DC</u>			d. STREET ADDRESS <u>6112 McArthur Blvd - Wash 16-DC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Charles Edward Trizzell</u>			4. DATE OF DEATH <u>Apr 19 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G'Town. Elec Co</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Chas R. Trizzell</u>		
14. MOTHER'S MAIDEN NAME <u>Charlotte Holt</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>		
16. SOCIAL SECURITY NO. <u>579-03-3243</u>			17. INFORMANT <u>Betha Trizzell (wife) Strum 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause last. DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-19-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>	22d. LOCATION (City, town, or county)	(State)	<u>FT MYER VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co, 3012 - M St. N.W. Wash 7, D.C.</u>		24a. REC'D BY REGISTRAR <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4539

## CERTIFICATE OF DEATH

04510

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> 16x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>2214 Phelps Road, Apt. A.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Thomas</u> Last <u>GIBSON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-85</u>	9. AGE (In years last birthday) yrs. <u>73</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Thomas GIBSON</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn SHUBERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Hospital Records</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL ISCHEMIA, EXTENSIVE</u> DUE TO <u>177x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPOTENSION (SHOCK)</u> DUE TO <u>CARCINOMA OF PROSTATE WITH WIDESPREAD</u> (c) <u>METASTASES TO LIVER, LUNGS, RIBS, BRAIN</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> <u>8 HOURS</u> <u>3 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>April 19</u> , 19 <u>59</u> , to <u>April 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>59</u> , and that death occurred at <u>1:00P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. S. Caldwell</u>		M.D. <u>U. S. Naval Hospital, NNMC</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>4-25-59</u>	
PHYSICIAN'S NAME (Type) <u>F. S. CALDWELL, LT, MC, USN</u>		<u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county)		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Humphrey</u>		ADDRESS <u>Funeral Home, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Weekday

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF BURIAL PLACE

18. SIGNATURE OF INTERVIEWER

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4540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Winchester</b> <b>83x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clinical Center N.O.H.O.</b>				d. STREET ADDRESS <b>1611 Valley Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Gilbert</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> , Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-1896</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>beautician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Winfield S. Sherman</b>				14. MOTHER'S MAIDEN NAME <b>Joanna E. Whisson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Hosp. Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hematoma (rt)</b> <b>902.7</b> DUE TO <b>Fall from Hosp. bed.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fall from Hosp. bed.</b> DUE TO (c) <b>Fall from Hosp. bed.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myeloid Metaplasia 7 yrs</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from bed Winchester Va. Memorial Hosp.</b>					
20c. TIME OF INJURY Month, Day, Year <b>4-22-59</b> Hour a. m. <b>4:35</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hosp</b>		20f. (City or town) (County) (State) <b>Winchester Frederick Va</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>4-25-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/27/59</b>		22b. DATE THEREOF <b>4/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>7557 main ave Bethesda, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	
				24a. REC'D BY REGISTRAR <b>APR 28 '59</b>			

NEW YORK  
DEPT. OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male	
3. AGE 45		4. COLOR White	
5. DATE OF DEATH 10/15/1918		6. PLACE OF DEATH Home	
7. OCCUPATION Clerk		8. CAUSE OF DEATH Pneumonia	
9. MANNER OF DEATH Natural		10. SIGNATURE OF EXAMINER J. H. Smith	
11. SIGNATURE OF NEXT OF KIN J. H. Brown		12. SIGNATURE OF WITNESSES J. H. Brown, J. H. Smith	
13. SIGNATURE OF REGISTRAR J. H. Brown		14. SIGNATURE OF CLERK J. H. Brown	
15. SIGNATURE OF CHIEF CLERK J. H. Brown		16. SIGNATURE OF ASSISTANT CLERK J. H. Brown	
17. SIGNATURE OF DEPUTY CLERK J. H. Brown		18. SIGNATURE OF CLERK IN CHARGE J. H. Brown	
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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4541

Items 8-9 Film G241 4-23-59 et

CERTIFICATE OF DEATH

04512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. STREET ADDRESS <b>7025 Strathmore Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>E.</b> Last <b>Glasco</b>		4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881 Oct. 20, 1877</b>
9. AGE (In years last birthday) <b>77 1/2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry P. Helwig</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>H. Norman Glasco</b>		Address <b>Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>10 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma, right breast</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/16/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/16/59</b> , 19 <b>59</b> , and that death occurred at <b>3 p.</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>4890 Battery Lane, Bethesda</b> DATE SIGNED <b>4/17/59</b>	
ACTUAL SIGNATURE <b>Charles J. Savarise, Jr.</b>		M.D. <b>4890 Battery Lane, Bethesda</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES J. SAVARISE, Jr., M.D.</b>		<b>14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-18-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821-14th St. N.W. D.C.</b>	
24a. REC'D BY REGISTRAR <b>APR 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kossel</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4542

## CERTIFICATE OF DEATH

Reg. Dist. No.

04513

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. STREET ADDRESS <u>700 Cabin Branch Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Wayne</u> Last <u>Godbold</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 10, 1957</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James E. Godbold</u>		14. MOTHER'S MAIDEN NAME <u>Merle Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cystic Fibrosis of Pancreas</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3-4 Weeks</u> <u>26 Months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>59</u> , to <u>April 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>59</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>4/23/59</u> ACTUAL SIGNATURE <u>Lowell K. Good</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>LOWELL K. GOOD, M.D.</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. K...</u>			

CERTIFICATE OF DEATH

1942

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Race _____		Birth Date _____	
Place of Birth _____		Usual Residence _____	
Cause of Death _____		Manner of Death _____	
Physician's Name _____		Hospital Name _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Certificate _____		Place of Death _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4472

CERTIFICATE OF DEATH

4514  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>6 1/2 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> <u>1622</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		d. STREET ADDRESS <u>4711 Homer ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>May</u> Last <u>Gorman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-94</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
13. FATHER'S NAME <u>Paradise Kelly</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Pr's chart.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tetany (hypocalcemic) severe</u> DUE TO <u>cardiac arrhythmia and acute cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe chronic pyelonephritis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1959</u> , to <u>April 12, 1959</u> , that I last saw the deceased alive on <u>April 12, 1959</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum.</u>		DATE SIGNED <u>April 13 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Heider Hill</u>	22d. LOCATION (City, town or county) (State) <u>Suitland Prince Georges Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		24a. REC'D BY REGISTRAR <u>APR 15 '59</u>	
ADDRESS <u>1661 Good Hope Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

1915

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. SMITH		Male		45		Jan 15, 1870		Baltimore, Md.		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PRESENT ILLNESS		15. PREVIOUS ILLNESS		16. MEDICAL ATTENDANCE	
Jan 20, 1915		10:30 AM		Home		Heart Failure		Coronary Artery Disease		Began 10 days before death		None		Physician: Dr. J. H. Jones	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF CLERK		22. SIGNATURE OF JUDGE		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CORONER	

Baltimore, Md.



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4543

## CERTIFICATE OF DEATH

04515

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1000 Dale Drive</b>				d. STREET ADDRESS <b>1000 Dale Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAUL</b> Middle <b>GREBER</b> Last <b>GREBER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1907</b>		9. AGE (In years lost birthday) yrs. <b>51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice-President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Wholsalers</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Greber</b>				14. MOTHER'S MAIDEN NAME <b>Sonia Cohen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Joseph Greber - 1966 Rosemary Hills Dr., S.S., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , 19, to <b>4/25/59</b> , 19, that I last saw the deceased alive on <b>4/25/59</b> , 19, and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>915-19th St. N.W.</b> DATE SIGNED <b>4/25/59</b>							
ACTUAL SIGNATURE <b>Herbert Abrahamson</b> M.D.				PHYSICIAN'S NAME (Type) <b>HERBERT ABRAHAMSON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>United Hebrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons-3501 14th St., N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G242 5-12-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

04516

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ada</b> First Middle Last <b>Greenblatt</b>		4. DATE OF DEATH <b>April 26, 1959</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>79</b> yrs.
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Latvia</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Arnold Sookne S. Spg.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant melanoma</b> <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 26, 1959</b> , to <b>April 26, 1959</b> , that I last saw the deceased alive on <b>April 26, 1959</b> , and that death occurred at <b>1:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sydney Leventhal</b> M.D.		ADDRESS (Street, city or town, state) <b>9210 Colemont Rd. Silver Spring Md</b> DATE SIGNED <b>4/26/59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr 28-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Fun. Home</b> ADDRESS <b>4217 9th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>APR 29 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

Washington, D.C.

CERTIFICATE OF DEATH

Page No. 11

<p>1. NAME OF DECEASED                  [Illegible Name]</p>		<p>2. SEX                  [Illegible]</p>	
<p>3. AGE                  [Illegible]</p>		<p>4. DATE OF BIRTH                  [Illegible]</p>	
<p>5. PLACE OF BIRTH                  [Illegible]</p>		<p>6. OCCUPATION                  [Illegible]</p>	
<p>7. MARITAL STATUS                  [Illegible]</p>		<p>8. CAUSE OF DEATH                  [Illegible]</p>	
<p>9. MEDICAL HISTORY                  [Illegible]</p>		<p>10. DATE OF DEATH                  [Illegible]</p>	
<p>11. PLACE OF DEATH                  [Illegible]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Illegible Signature]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Illegible Signature]</p>		<p>14. OFFICIAL SEAL                  [Illegible Seal]</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

4545

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04517

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>7 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Le Beau Gardens</i>		d. STREET ADDRESS <i>E. End Parkway Forest St.</i>	
3. NAME OF DECEASED (Type or print) <i>Bertha</i> First Middle Last <i>Gingrich</i>		4. DATE OF DEATH <i>Apr 14 1959</i> Month Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 20 1888</i> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Wash, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Gingrich</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Friend</i> Address <i>David Palmer Hanisling, Pa.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Dilatation</i> <i>154X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic heart Failure</i> DUE TO (c) <i>Hypertensive Co. Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>2 wks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Double hernia abdominal</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 19 1958</i> to <i>Apr 14 1959</i> , that I last saw the deceased alive on <i>Apr 14 1959</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert J. Thibadeau</i> M.D.		ADDRESS (Street, city or town, state) <i>10609 CONCORD ST. N.W.</i>	
DATE SIGNED <i>APR 16 1959</i>			
PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>		<i>KENSINGTON, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>4/15/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Shadensburg Rd Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i>		24. REC'D BY REGISTRAR <i>March 5C</i>	
25. DATE <i>APR 16 1959</i>		26. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4546

## CERTIFICATE OF DEATH

04518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8811 BRADFORD ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>THOMAS</u> Middle <u>Grimes Sr.</u> Last		4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>1959</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LITHOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLIAM GRIMES</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. OWENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-03-6053</u>	
17. INFORMANT <u>Mrs. Edith M. Grimes, 8811 Bradford Rd.</u> Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic gastric carcinoma</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 4</u> , 19 <u>58</u> , to <u>April 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>59</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Harry N. Carlton</u> M.D. <u>940 - 25th St., N.W. Wash DC 4/27/59</u> PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MD.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04519

Reg. Dist. No.

4473

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges Co</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1712 Lebanon ST. Langley Park Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp.</u>			d. STREET ADDRESS <u>16X-2</u>		
3. NAME OF DECEASED (Type or print) <u>James Anthony Hanley</u>			4. DATE OF DEATH <u>4-30-59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/59</u>		9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Terminal Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>	
13. FATHER'S NAME <u>Thomas Hanley</u>			14. MOTHER'S MAIDEN NAME <u>Mary ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII - Navy</u>			16. SOCIAL SECURITY NO. <u>WWT - Navy</u>		
17. INFORMANT <u>Wife - Mrs. Marie Hanley</u>			Address <u></u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bruschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHART</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>5/4/59</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LEBANON</u>			22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES CO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Linder</u>			24a. REC'D BY REGISTRAR <u>DATE MAY 4 '59</u>		
ADDRESS <u>1756 Penn. Ave. N.W.</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15-12

DEATH CERTIFICATE

UNITED STATES

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WARD OF BALTIMORE

STREET OF BALTIMORE

APARTMENT OF BALTIMORE

ROOM OF BALTIMORE

FLOOR OF BALTIMORE

SECTION OF BALTIMORE

QUARTER OF BALTIMORE

LOT OF BALTIMORE

BLK. OF BALTIMORE

TRACED OF BALTIMORE

DEPT. OF BALTIMORE

OFFICE OF BALTIMORE

4547

## CERTIFICATE OF DEATH

04520

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> <b>COLUMBIA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, 8, D. C.</b> <b>47X-3</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>3619 Chesapeake St. NW.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lauriston</b> Middle <b>Halbert</b> Last <b>Hannah</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/10/1885</b>	
9. AGE (In years lost birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>		IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance Co.</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James P. Hannah</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Covington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Mary Conlon Hannah</b>		17. INFORMANT <b>Mary Conlon Hannah</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Thrombosis</b> <b>466X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Venous Thrombosis of the Rt. lower extremity</b> DUE TO (c) <b>Acute Monocytic Leukemia</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1957</b> , to <b>April 20, 1959</b> , that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above. <b>Robert H. Coale</b> M.D. <b>4630 Montgomery Ave., Bethesda Md 4/20/59</b> ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>ROBERT N. COALE</b>				PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4/22/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. Hanna CO -</b>				ADDRESS <b>2901-14th ST. N. W.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES M. JONES		M		35		W		1968		BALTIMORE, MARYLAND	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH		10. DATE OF BIRTH		11. SEX OF BIRTH		12. RACE OF BIRTH	
HEART DISEASE		NATURAL		BALTIMORE, MARYLAND		1933		M		W	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS		17. PREVIOUS ALCOHOL		18. PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF WITNESS		22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
25. DATE OF CERTIFICATE		26. TIME OF CERTIFICATE		27. PLACE OF CERTIFICATE		28. COUNTY OF CERTIFICATE		29. STATE OF CERTIFICATE		30. FEDERAL BUREAU OF INVESTIGATION	
1968		10:00 AM		BALTIMORE, MARYLAND		BALTIMORE		MARYLAND		[Stamp]	



4548

## CERTIFICATE OF DEATH

04521

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5670 Rockville Pike, Rockville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harvest Nursing Home</u>		d. STREET ADDRESS <u>1571-26th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>E.</u> Middle <u>HANNER</u> Last		4. DATE OF DEATH <u>APRIL 11</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Anna Gosling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>710</u>	
17. ADDRESS <u>Blanch Buscher, 4319-512 Rd. Arl. Va.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture hip left 29 Jan 59</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home during night</u>	
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>o. m.</u> <u>JAN 29, 1959</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Takoma Park, Mont. Md.</u>
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>58</u> to <u>11 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 April</u> , 19 <u>59</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas P Fogarty</u> M.D. <u>8012 Old Riggs Rd Hyattsville Md.</u>		DATE SIGNED <u>11-59</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS P FOGARTY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-14-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>	22d. LOCATION (City, town, or county) (State) <u>Arl. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>5072-14 St N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A Brosehard notified  
Coroner will approve  
and will approve  
Hogarty M

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4549

CERTIFICATE OF DEATH

04522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 days, 5½ hrs.</b> <b>26</b> <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>1 1006 Neal Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b> First <b>Hannoway</b> Middle <b>Jr.</b> Last <b>Hannoway</b>		4. DATE OF DEATH <b>April</b> Month <b>12</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/59</b>
9. AGE (In years last birthday) yrs. <b>2</b> <b>5½</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>5½</b> IF UNDER 24 HRS. Hours <b>5½</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George R. Hannoway</b>		14. MOTHER'S MAIDEN NAME <b>Varity I. Ingram</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George R. Hannoway</b>		Address <b>1006 Neal Drive Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>770.0</b> <b>Cryptothroblastosis fetalis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS 5½ HRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>BILOBULAR ATELECTASIS</b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>APRIL 10, 1959</b> to <b>APRIL 12, 1959</b> , that I last saw the deceased alive on <b>APRIL 12, 1959</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ira W. Pearlman</b> M.D.		ADDRESS (Street, city or town, state) <b>4700 BRADLEY BLVD. ARLINGTON, VA.</b> DATE SIGNED <b>APR 13, 59</b>	
PHYSICIAN'S NAME (Type) <b>IRA W. PEARLMAN MD.</b>		<b>CHAS. CHASE MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>

2074244XV3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4550 CERTIFICATE OF DEATH

04523

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			c. LENGTH OF STAY IN IB since <b>Nov 1956</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3911 Dresden Street</b>				d. STREET ADDRESS <b>3911 Dresden St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Myrtle</b> Middle <b>Rutledge</b> Last <b>Haynes</b>				<b>4. DATE OF DEATH</b> Month <b>Apr</b> Day <b>19</b> Year <b>1959</b>									
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 10, 1871</b>		<b>9. AGE</b> (In years last birthday) <b>87</b> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days Hours Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Woodward &amp; Lothrop, Jewelry Dept.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Iowa</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>William Mathews Rutledge</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Eleanor Eicher</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Ida Rutledge Bohannon</b> <span style="float: right;">Address <b>Kensington, Md. 3911 Dresden St.</b></span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary thrombosis</b> DUE TO (c) <b>atherosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that I attended the deceased from <b>9-1-58</b> , to <b>4-18-59</b> , that I last saw the deceased alive on <b>4-18-59</b> , and that death occurred at <b>9:00</b> M., from the causes and on the date stated above.													
<b>ACTUAL SIGNATURE</b> <b>Paula E. Mahler</b>				<b>ADDRESS</b> (Street, city or town, state) <b>5311 Roosevelt St Bethesda, Md.</b> <b>DATE SIGNED</b>									
<b>PHYSICIAN'S NAME (Type)</b> <b>Paula E. Mahler</b>													
<b>22a. BURIAL-CREATION. REMOVAL (Specify)</b> <b>removal</b>			<b>22b. DATE THEREOF</b> <b>4/23/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b>			<b>22d. LOCATION</b> (City, town, or county) (State) <b>Utica, Nebraska</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H.Hines Co., 2901 14th St. N.W.,</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE APR 21 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>					

CERTIFICATE OF DEATH

2520

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
MURIEL E. HARRIS		F		38		JAN 10 1901	
PLACE OF BIRTH		RACE		OCCUPATION		CAUSE OF DEATH	
BALTIMORE, MARYLAND		WHITE		HOUSEWIFE		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAN 15 1939		BALTIMORE, MARYLAND		NATURAL		2520	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		MANNER	
JAN 15 1939		10:30 AM		BALTIMORE, MARYLAND		NATURAL	
NAME OF PHYSICIAN		NAME OF REGISTRAR		NAME OF WITNESS		NAME OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		MANNER	
JAN 15 1939		10:30 AM		BALTIMORE, MARYLAND		NATURAL	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04524

4551

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>elmer</i>		c. LENGTH OF STAY IN 1b <i>17 Takema Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>8517 Flower Ave</i> <i>7718 Willow Ave</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry G Heath</i>		4. DATE OF DEATH Month Day Year <i>April 30 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13, 1880</i>
9. AGE (In years last birthday) yrs. <i>78</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Thomas Heath</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Hall</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Mrs Bingham</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>chronic nephritis</i> <i>592X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/17</i> , 19 <i>59</i> , to _____, 19____, that I last saw the deceased alive on <i>4/25</i> , 19 <i>59</i> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Sandy Spring</i> M.D. <i>Sandy Spring</i>			
ACTUAL SIGNATURE <i>J.W. Bird</i>		PHYSICIAN'S NAME (Type) <i>J.W. Bird</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>5/4/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 4 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>			



MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57

*[Faint, illegible vertical text visible through the paper]*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4553

## CERTIFICATE OF DEATH

04526

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>Qtrs. "E", Naval Gun Factory</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katherine Elizabeth HERLIHY</b>				4. DATE OF DEATH Month Day Year <b>April 1 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-10-05</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John HENCHEY</b>				14. MOTHER'S MAIDEN NAME <b>Grace DILLON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(H) Capt. Thomas C. Herlihy, SC, USN, #2 above</b>		Address <b>same as</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>LAENNEC'S CIRRHOSIS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 26</b> , 19 <b>59</b> , to <b>April 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 1</b> , 19 <b>59</b> , and that death occurred at <b>2:53P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-2-59</b>							
ACTUAL SIGNATURE <b>John Wood Davis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>J. W. DAVIS LT MC USN</b>				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>4-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Belmont Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Belmont Mass.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Gwaler</b> ADDRESS <b>Washington, DC</b>				24a. REC'D BY REGISTRAR <b>APR 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	
<b>Joseph Gawler's &amp; Sons, 1756 Penn. Ave., NW,</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4554

## CERTIFICATE OF DEATH

04527  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Damascus</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 3, Mt. Airy</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Damascus</b>			
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>March</b> Last <b>Herndon</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1890</b>	9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown McNealy</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mr. George T. Herndon, Mt. Airy, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 years.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b>19</b> Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>4/10</b> , 19 <b>51</b> , to <b>4/14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/13</b> , 19 <b>59</b> , and that death occurred at <b>11:50 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>4/14/59</b>							
ACTUAL SIGNATURE <b>James P. Kerr</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Howard Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Long Corner, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas L. Moleworth</b>		ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 1, 1960		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. DATE OF BIRTH March 1, 1895		11. SEX OF BIRTH Male		12. AGE AT BIRTH 65	
13. NAME OF FATHER John H. Harris		14. NAME OF MOTHER Mary E. Harris		15. NAME OF SPOUSE Elizabeth Harris	
16. NAME OF PHYSICIAN Dr. J. H. Harris		17. NAME OF NURSE Mrs. J. H. Harris		18. NAME OF MINISTER Rev. J. H. Harris	
19. NAME OF CLERGYMAN Rev. J. H. Harris		20. NAME OF CHURCH St. John's Church		21. NAME OF FUNERAL HOME St. John's Church	
22. NAME OF BURIAL PLACE St. John's Church		23. NAME OF CEMETERY St. John's Church		24. NAME OF INTERMENT St. John's Church	
25. NAME OF INTERMENT St. John's Church		26. NAME OF INTERMENT St. John's Church		27. NAME OF INTERMENT St. John's Church	
28. NAME OF INTERMENT St. John's Church		29. NAME OF INTERMENT St. John's Church		30. NAME OF INTERMENT St. John's Church	
31. NAME OF INTERMENT St. John's Church		32. NAME OF INTERMENT St. John's Church		33. NAME OF INTERMENT St. John's Church	
34. NAME OF INTERMENT St. John's Church		35. NAME OF INTERMENT St. John's Church		36. NAME OF INTERMENT St. John's Church	
37. NAME OF INTERMENT St. John's Church		38. NAME OF INTERMENT St. John's Church		39. NAME OF INTERMENT St. John's Church	
40. NAME OF INTERMENT St. John's Church		41. NAME OF INTERMENT St. John's Church		42. NAME OF INTERMENT St. John's Church	
43. NAME OF INTERMENT St. John's Church		44. NAME OF INTERMENT St. John's Church		45. NAME OF INTERMENT St. John's Church	
46. NAME OF INTERMENT St. John's Church		47. NAME OF INTERMENT St. John's Church		48. NAME OF INTERMENT St. John's Church	
49. NAME OF INTERMENT St. John's Church		50. NAME OF INTERMENT St. John's Church		51. NAME OF INTERMENT St. John's Church	
52. NAME OF INTERMENT St. John's Church		53. NAME OF INTERMENT St. John's Church		54. NAME OF INTERMENT St. John's Church	
55. NAME OF INTERMENT St. John's Church		56. NAME OF INTERMENT St. John's Church		57. NAME OF INTERMENT St. John's Church	
58. NAME OF INTERMENT St. John's Church		59. NAME OF INTERMENT St. John's Church		60. NAME OF INTERMENT St. John's Church	
61. NAME OF INTERMENT St. John's Church		62. NAME OF INTERMENT St. John's Church		63. NAME OF INTERMENT St. John's Church	
64. NAME OF INTERMENT St. John's Church		65. NAME OF INTERMENT St. John's Church		66. NAME OF INTERMENT St. John's Church	
67. NAME OF INTERMENT St. John's Church		68. NAME OF INTERMENT St. John's Church		69. NAME OF INTERMENT St. John's Church	
70. NAME OF INTERMENT St. John's Church		71. NAME OF INTERMENT St. John's Church		72. NAME OF INTERMENT St. John's Church	
73. NAME OF INTERMENT St. John's Church		74. NAME OF INTERMENT St. John's Church		75. NAME OF INTERMENT St. John's Church	
76. NAME OF INTERMENT St. John's Church		77. NAME OF INTERMENT St. John's Church		78. NAME OF INTERMENT St. John's Church	
79. NAME OF INTERMENT St. John's Church		80. NAME OF INTERMENT St. John's Church		81. NAME OF INTERMENT St. John's Church	
82. NAME OF INTERMENT St. John's Church		83. NAME OF INTERMENT St. John's Church		84. NAME OF INTERMENT St. John's Church	
85. NAME OF INTERMENT St. John's Church		86. NAME OF INTERMENT St. John's Church		87. NAME OF INTERMENT St. John's Church	
88. NAME OF INTERMENT St. John's Church		89. NAME OF INTERMENT St. John's Church		90. NAME OF INTERMENT St. John's Church	
91. NAME OF INTERMENT St. John's Church		92. NAME OF INTERMENT St. John's Church		93. NAME OF INTERMENT St. John's Church	
94. NAME OF INTERMENT St. John's Church		95. NAME OF INTERMENT St. John's Church		96. NAME OF INTERMENT St. John's Church	
97. NAME OF INTERMENT St. John's Church		98. NAME OF INTERMENT St. John's Church		99. NAME OF INTERMENT St. John's Church	
100. NAME OF INTERMENT St. John's Church		101. NAME OF INTERMENT St. John's Church		102. NAME OF INTERMENT St. John's Church	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

315  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04528  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>X Kensington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3935 Baltimore Street</b>		d. STREET ADDRESS <b>3925 Baltimore Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS A. N. HINDMAN</b> First Middle Last		4. DATE OF DEATH <b>April 28, 1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>11</b> IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>M.D.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>A. O. Hindman</b>	
14. MOTHER'S MAIDEN NAME <b>Ada NewCommer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes WW 11</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Margaret Hindman-Item # 2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/28/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>

FOR STATE  
HEALTH OFF

Montgomery

Maryland

Kenilworth

Kenilworth

3022 Baltimore Street

3022 Baltimore Street

April 20, 1917

FRANCIS A. HINDMAN

Info White female 46

Physician Pennsylvania

O. Hindman Ada Newcomer

Maryland Kenilworth 2

Coroner's Occupation

Kenilworth



Frank J. Brochert

Kenilworth

Kenilworth

Kenilworth







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4557

CERTIFICATE OF DEATH

04531

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Christiansburg</b> d. STREET ADDRESS <b>Route # 1, Box 596</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Allen</b> Last <b>Howard</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7, 1952</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Student)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) yrs. <b>7</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edgar R. Howard</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.2 Congenital Heart Disease - Ventricular Septal Defect</b> DUE TO (b) <b>Patent Ductus Arteriosus - Postoperative repair of (a)</b> DUE TO (c) <b>Pulmonary Congestion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 29</b> , 19 <b>59</b> , to <b>April 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 2</b> , 19 <b>59</b> , and that death occurred at <b>6:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/3/59</b> ACTUAL SIGNATURE <b>William W. Pfaff, M.D.</b> PHYSICIAN'S NAME (Type) <b>William W. Pfaff, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <b>Christiansburg, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co.</b> ADDRESS <b>1400 Chapin St. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

CERTIFICATE OF DEATH

Name (Print Name)		Date of Birth	
John H. Jones		January 1, 1900	
Sex (Male or Female)		Race (Caucasian, Negro, etc.)	
Male		Caucasian	
Married (Yes or No)		Occupation	
Yes		Farmer	
Cause of Death (Print Name)		Date of Death	
Heart Disease		January 15, 1950	
Place of Death (Print Name)		Time of Death	
Home		10:00 AM	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Print Name of Physician		Print Name of Registrar	
John H. Jones		John H. Jones	
Address (Print Name)		City (Print Name)	
123 Main St.		Baltimore, Md.	
State (Print Name)		County (Print Name)	
Maryland		Baltimore	
Date of Report		Time of Report	
January 16, 1950		11:00 AM	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04532

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>7 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12031 Claridge Rd</u>			d. STREET ADDRESS <u>12031 Claridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Leonard Forest Humphries Jr.</u>			4. DATE OF DEATH <u>Apr 20 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-26</u>		9. AGE (In years last birthday) <u>33</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>delivery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Leonard F. Humphries, SR.</u>			14. MOTHER'S MAIDEN NAME <u>Lillie Grey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW #2</u>		16. SOCIAL SECURITY NO. <u>226-20-2054</u>		17. INFORMANT <u>Evelyn Humphries (wife)</u> Address <u>Blm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>974X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hanging</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck in basement of his home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-20-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RICHMOND, VIRGINIA</u>	
22d. LOCATION (City, town, or county) _____ (State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>APR 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thomas</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4559

## CERTIFICATE OF DEATH

04533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>3914 Bruce Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>Coleman</b> Last <b>Hurd</b>			4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1903</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
13. FATHER'S NAME <b>Elijah Hurd</b>			14. MOTHER'S MAIDEN NAME <b>Corrinna Coleman</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>229-24-4913</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, subendocardial</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>8 hrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Histioplasma granulomas, lung, spleen, liver, lymph nodes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>nodes</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 28, 1959</b> to <b>April 7, 1959</b> , that I last saw the deceased alive on <b>April 7, 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-7-59</b>							
ACTUAL SIGNATURE <b>Albert Treger</b> PHYSICIAN'S NAME (Type) <b>Albert Treger, m.d.</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>104 HILL CEMETERY</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wheatley Funeral Home</b> <b>By J. S. Every</b>		ADDRESS <b>Alexandria, Va.</b>		24a. REC'D BY REGISTRAR <b>APR 10 '59</b> DATE			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF SURVIVOR

DATE OF DEATH OF SURVIVOR

NAME OF SURVIVOR

DATE OF DEATH OF SURVIVOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 TSM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4560

## CERTIFICATE OF DEATH

04534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>17 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ropin Nursing Home</b>				/d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Stephen</b> Last <b>Hurt</b>			4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec-12-1868</b>		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farm owner</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>George Hurt</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Wiley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Miss Della Hurt, 270-R.I. Ave N.E., Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO <b>Generalized Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>8 years</b> <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April, 1950</b> to <b>1 April, 1959</b> , that I last saw the deceased alive on <b>31 March 1959</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Barnesville, Md. 1 Apr 59</b> ACTUAL SIGNATURE <b>Gordon M. Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Boonville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Barnesville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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end

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4561

## CERTIFICATE OF DEATH

04535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47 X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>475 Ridge Street, N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Jane</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1902</b>	
9. AGE (In years lost birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housecleaner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Jim Peters</b>				14. MOTHER'S MAIDEN NAME <b>Ann Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-46-5121</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PYELONEPHRITIS</b> DUE TO (c) <b>CARCINOMA OF CERVIX</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>6 WKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March 10</b> , 19 <b>59</b> , to <b>April 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 16</b> , 19 <b>59</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>4-19-59</b> DATE SIGNED ACTUAL SIGNATURE <b>Jack H. Bloch, M.D.</b> PHYSICIAN'S NAME (Type) <b>Jack H. Bloch, M. D.</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-22-59</b>				22b. DATE THEREOF <b>4-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
22d. LOCATION (City, town, or county) <b>Wash. D.C.</b>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick's Fun. Home, Inc.</b>				ADDRESS <b>389 R.D. Urdrew</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thane</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

NAME OF DECEASED JOHN J. HARRIS  
 SEX MALE AGE 45 YEARS  
 DATE OF DEATH SEP 12 1911  
 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE  
 DISEASE OR INJURY HEART DISEASE  
 PERIOD OF ILLNESS 2 WEEKS

PLACE OF BIRTH IRELAND  
 OCCUPATION LABORER  
 MARITAL STATUS MARRIED

EDUCATION COMMON SCHOOL  
 RELIGION CATHOLIC  
 SERVICE IN ARMY OR NAVY NO

PREVIOUS ILLNESS NO  
 PREVIOUS SURGERY NO  
 PREVIOUS TRAUMA NO

PREVIOUS ALCOHOLIC DRINKING NO  
 PREVIOUS TOBACCO SMOKING NO  
 PREVIOUS OPIUM SMOKING NO

PREVIOUS DRUG ABUSE NO  
 PREVIOUS EPILEPSY NO  
 PREVIOUS TUBERCULOSIS NO

PREVIOUS DIABETES NO  
 PREVIOUS HYPERTENSION NO  
 PREVIOUS RHEUMATISM NO

PREVIOUS GOUT NO  
 PREVIOUS BRUISES OR SCALDS NO  
 PREVIOUS FROSTBITE NO

PREVIOUS OTHER DISEASES NO  
 PREVIOUS INJURIES NO  
 PREVIOUS TRAUMA NO

PREVIOUS SURGERY NO  
 PREVIOUS TRAUMA NO  
 PREVIOUS ALCOHOLIC DRINKING NO

PREVIOUS TOBACCO SMOKING NO  
 PREVIOUS OPIUM SMOKING NO  
 PREVIOUS DRUG ABUSE NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4562

## CERTIFICATE OF DEATH

04536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>37 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 56</b> d. STREET ADDRESS <b>136 Colony Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jeffrey</b> Middle <b>Lynn</b> Last <b>Jacobson</b>			4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1957</b>	9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>			
13. FATHER'S NAME <b>James L. Jacobson</b>			14. MOTHER'S MAIDEN NAME <b>Jeanne LaRock</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>155.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hepatoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>1 yr.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 6, 1959</b> to <b>April 12, 1959</b> , that I last saw the deceased alive on <b>April 12, 1959</b> , and that death occurred at <b>1:15a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>4-12-59</b>							
ACTUAL SIGNATURE <i>G. Richard Lee</i>		M.D. <b>G. Richard Lee, M. D.</b>					
PHYSICIAN'S NAME (Type) <b>G. Richard Lee, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit 4/15/59</b>		22b. DATE THEREOF <b>4/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Lawn Mem. Cem</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 14 '59</b>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hane</i>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4563  
CERTIFICATE OF DEATH

04537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>142 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Washington</b> d. STREET ADDRESS <b>5518 C Street, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>(none)</b> Last <b>Joe</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1890</b>
9. AGE (In years lost birthday) yrs. <b>69</b>		IF UNDER 1 YEAR: Months <b>19</b> Days <b>29</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joe Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Vinie McDaniel</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gas tro Intestinal Hemorrhage</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Gastric Ulcers</b> DUE TO (c) <b>Carcinoma of Cervix</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 8, 19 58</b> to <b>April 29, 19 59</b> , that I last saw the deceased alive on <b>April 29, 19 59</b> , and that death occurred at <b>1:30p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>JACK H. BLOCH, M.D.</b> PHYSICIAN'S NAME (Type) <b>JACK H. BLOCH, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>4/30/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thomas</b> ADDRESS <b>30 H Street, N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

CERTIFICATE OF DEATH

1934

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St, Boston		Teacher		Heart Disease	
Date of Death		Place of Death		Physician	
Jan 15, 1934		Home		Dr. Smith	
Time of Death		Manner of Death		Burial	
10:30 AM		Natural		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Deceased	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Official Seal	
Jan 16, 1934		Boston		[Seal]	



1884

CERTIFICATE OF DEATH

1884

DEATH RECORD

DEATH RECORD

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4565

## CERTIFICATE OF DEATH

Reg. Dist. No.

04539

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2701 Georgia Ave N.W.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ELIZABETH P. JOHNSON</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>17</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12-8-1986</u>	
<b>9. AGE</b> (In years last birthday) <u>72 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>2</u>		<b>IF UNDER 24 HRS.</b> Hours <u>17</u> Min. <u>59</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Richard P. Ennis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Pendleton</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> (Brother) <u>Richard A. Ennis</u> Address <u>1305 Hemlock St NW</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema, congestion</u> DUE TO (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Coronary thrombosis</u> Arterial Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Duodenal ulcer chronic recurrent (old)</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a. m. p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>Apr 7, 1959</u> , to <u>Apr 17, 1959</u> , that I last saw the deceased alive on <u>Apr 16, 1959</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>George L. Ball</u> M.D.				<b>DATE SIGNED</b> <u>Apr 17, 1959</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>George L. Ball</u>				<b>ADDRESS</b> (Street, city or town, state) <u>7835 Eastern Ave Silver Spring Md</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u>		<b>22b. DATE THEREOF</b> <u>4-20-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>SUITLAND, MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Martin W. Hysong Co. Inc.</u> ADDRESS <u>1300-N St NW WASH. D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 20 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hays</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee		6. COUNTY Baltimore		7. STATE Maryland		8. CITY Baltimore	
9. OCCUPATION None		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. MEDICAL HISTORY None	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None		16. PREVIOUS DRUGS None	
17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None		19. PREVIOUS OTHER None		20. PREVIOUS OTHER None	
21. PREVIOUS OTHER None		22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None		28. PREVIOUS OTHER None	
29. PREVIOUS OTHER None		30. PREVIOUS OTHER None		31. PREVIOUS OTHER None		32. PREVIOUS OTHER None	
33. PREVIOUS OTHER None		34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None		40. PREVIOUS OTHER None	
41. PREVIOUS OTHER None		42. PREVIOUS OTHER None		43. PREVIOUS OTHER None		44. PREVIOUS OTHER None	
45. PREVIOUS OTHER None		46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None		52. PREVIOUS OTHER None	
53. PREVIOUS OTHER None		54. PREVIOUS OTHER None		55. PREVIOUS OTHER None		56. PREVIOUS OTHER None	
57. PREVIOUS OTHER None		58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None		64. PREVIOUS OTHER None	
65. PREVIOUS OTHER None		66. PREVIOUS OTHER None		67. PREVIOUS OTHER None		68. PREVIOUS OTHER None	
69. PREVIOUS OTHER None		70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None		76. PREVIOUS OTHER None	
77. PREVIOUS OTHER None		78. PREVIOUS OTHER None		79. PREVIOUS OTHER None		80. PREVIOUS OTHER None	
81. PREVIOUS OTHER None		82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None		88. PREVIOUS OTHER None	
89. PREVIOUS OTHER None		90. PREVIOUS OTHER None		91. PREVIOUS OTHER None		92. PREVIOUS OTHER None	
93. PREVIOUS OTHER None		94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None		100. PREVIOUS OTHER None	

NOTED BY OFFICIAL

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A LICENSED NURSE



4566

04540

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>29 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b> d. STREET ADDRESS <b>115 Hesketh Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harvey Fletcher JOHNSON</b>				4. DATE OF DEATH Month Day Year <b>April 22 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-27-82</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Coast Guard</b>		11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Leander JOHNSON</b>			
14. MOTHER'S MAIDEN NAME <b>Sally THOMPSON</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Unknown Unknown</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, squamous cell, epiglottis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 24</b> , 19 <b>59</b> , to <b>April 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 21</b> , 19 <b>59</b> , and that death occurred at <b>2:14A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-22-59</b>							
ACTUAL SIGNATURE <b>G. W. Taylor Jr.</b> M.D. <b>U. S. Naval Hospital, NNMC</b>				DATE SIGNED <b>4-22-59</b>			
PHYSICIAN'S NAME (Type) <b>G. W. TAYLOR, JR., CDR, MC, USN Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE APR 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4567

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>47X-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District of Columbia (Washington)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Viola</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 6, 1916</b>	
9. AGE (In years last birthday) yrs. <b>42</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Parlor</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Arthur Jones</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Dandy</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular and renal disease</b> <b>442x</b> DUE TO <b>with uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>month</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 28</b> , 19 <b>58</b> , to <b>April 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 21</b> , 19 <b>59</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/22/59</b> ACTUAL SIGNATURE <b>Edgar Haber</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Edgar Haber, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEMORIAL</b>		22d. LOCATION (City, town, or county) (State) <b>4001 SUITLAND RD, S.E. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. F. Taylor</b>				ADDRESS <b>1702 12TH ST, N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

FILE NO.

11-587

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04542

Reg. Dist. No.

4568

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 15,</u> 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3737 Military Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Karchem</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/86</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
13. FATHER'S NAME <u>William C. Foxwell</u>				14. MOTHER'S MAIDEN NAME <u>Tinny Wrightson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Louis Karchem</u>	
				Address <u>3737 Military Rd.</u>		<u>Washington 15, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Cardio Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days.</u> <u>10 days.</u> <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis - Cerebral Vessels - 7 days.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/3</u> , 19 <u>59</u> , to <u>4/13/</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>59</u> , and that death occurred at <u>11:40 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John S. Ball</u> M.D. <u>7936 Georgetown Rd.</u> PHYSICIAN'S NAME (Type) <u>Bethesda 14 Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. DATE OF DEATH [Faint text]	
13. PLACE OF DEATH [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF NEXT OF KIN [Faint text]	
17. SIGNATURE OF BURIAL OFFICIAL [Faint text]		18. SIGNATURE OF CHURCH OFFICIAL [Faint text]	
19. SIGNATURE OF MINISTER [Faint text]		20. SIGNATURE OF CLERGYMAN [Faint text]	
21. SIGNATURE OF RABBI [Faint text]		22. SIGNATURE OF OTHER [Faint text]	
23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
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93. SIGNATURE OF OTHER [Faint text]		94. SIGNATURE OF OTHER [Faint text]	
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97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]	
99. SIGNATURE OF OTHER [Faint text]		100. SIGNATURE OF OTHER [Faint text]	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR AND THE PHYSICIAN. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. THE REGISTRAR'S SIGNATURE MUST BE IN THE SPACE PROVIDED FOR HIM. THE PHYSICIAN'S SIGNATURE MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE DECEASED, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE NEXT OF KIN, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE BURIAL OFFICIAL, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE CHURCH OFFICIAL, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE MINISTER, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE CLERGYMAN, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF THE RABBI, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM. THE SIGNATURE OF ANY OTHER PERSON, IF HE IS CAPABLE OF SIGNING, MUST BE IN THE SPACE PROVIDED FOR HIM.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4569

## CERTIFICATE OF DEATH

04543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bradley</b> Middle <b>Thomas</b> Last <b>King</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/8/67</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles King</b>				14. MOTHER'S MAIDEN NAME <b>Mittie Watkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Record</b>		Address <b>Olney, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Congestive Cardiac Failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>2 years</b> <b>? years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/15/55</b> , 19____, to <b>4/4/59</b> , 19____, that I last saw the deceased alive on <b>4/3/59</b> , 19____, and that death occurred at <b>1:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main Street</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>G. F. Meadors</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>G. F. Meadors, M.D.</b> <b>Damascus, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 6</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem. Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Cedar Grove Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b> ADDRESS <b>Laytonsville, Md</b>				24a. REC'D BY REGISTRAR <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9 FilmG241 4-27-59 et  
4570  
CERTIFICATE OF DEATH

04544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>34 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3336 Camden Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth B. Welch</u> <b>KLINE</b>				4. DATE OF DEATH Month Day Year <u>April 16</u> <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24 - 1877</u> <u>8187</u> yrs.	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Gilleott</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Posey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Joseph Welch (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated adenocarcinoma</u> <u>199.2</u> DUE TO <u>C metastasis to abdominal viscera</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 1958, to <u>16 April</u> , 1959, that I last saw the deceased alive on <u>1 April</u> , 1959, and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Heracle W. Bernier</u> M.D.				ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u> <u>Kensington, Md.</u>			
DATE SIGNED <u>4/17/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 20 - 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		22d. LOCATION (City, town, or county) (State) <u>Hilltop, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>				ADDRESS <u>1661 Good Hope</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

# CERTIFICATE OF DEATH

1910

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>Jan 15 1910</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>Jan 1 1865</i></p>		<p>PLACE OF BIRTH <i>Maryland</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>PREVIOUS ILLNESS <i>None</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1910</i></p>		<p>PLACE OF INTERMENT <i>Cemetery</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>SIGNATURE OF REGISTRAR <i>Wm. H. Jones</i></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4571

## CERTIFICATE OF DEATH

04545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>328 Terrell Avenue</b>							
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Anne</b> Last <b>Korhnak</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1955</b>	
9. AGE (In years last birthday) <b>4 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b> Hours <b>2</b>		11. IF UNDER 24 HRS. Months <b>4</b> Days <b>16</b> Hours <b>2</b>		12. IF UNDER 24 HRS. Months <b>4</b> Days <b>16</b> Hours <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Germany</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Ralph V. Korhnak</b>				14. MOTHER'S MAIDEN NAME <b>Ann Harrington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>196.6</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinoma of the hilum of the lung</b> DUE TO (c) <b>Undifferentiated carcinoma sacrum</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>3 Months</b> <b>7 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 26, 1959</b> to <b>April 26, 1959</b> , that I last saw the deceased alive on <b>April 26, 1959</b> , and that death occurred at <b>10:25 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/27/59</b> NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE <b>Nathan S. Taylor</b> M.D.				PHYSICIAN'S NAME (Type) <b>Nathan S. Taylor, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>4/29/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>SHAREVE PORT LOUISIANA</b>				22d. LOCATION (City, town, or county) (State) <b>SHAREVE PORT LOUISIANA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>RINALDI FUNERAL HOME</b>				24a. REC'D BY REGISTRAR <b>APR 28 1959</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

MEDICAL CERTIFICATION

Not considered a Medical Examiners case since this was the 3rd admission of this patient for Carcinoma.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

RECORDED AND INDEXED BY [Illegible] DATE [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 7 Film 242 5-12-59 et  
4474  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

04546

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Rest Home</u>		d. STREET ADDRESS <u>1415 Underwood St. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle <u>H.</u> Last <u>LAMBERT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John R. Lantz</u>		14. MOTHER'S MAIDEN NAME <u>Edna. Hammond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>9</u>	
17. INFORMANT <u>Robert L. Lambert</u>		Address <u>1415 Underwood St. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>CARCINOMA, COLON</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DR. BROSCHART NOTIFIED AND APPROVED</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH</u> 19 <u>57</u> to <u>APRIL 19</u> 19 <u>59</u> , that I last saw the deceased alive on <u>MARCH 2</u> 19 <u>59</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>13018 GEORGIA AVE</u>			
ACTUAL SIGNATURE <u>A.W. Smith</u>		M.D. <u>13018 GEORGIA AVE</u>	
PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>		<u>SILVER SPRING, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>		ADDRESS <u>4812 Br. Ave NW</u>	
24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>		DATE <u>May 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

MEDICAL CERTIFICATION



4572

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Wisner</b> Last <b>Lambright</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>20 May 1900</b>		9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gardening</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry A. Lambright</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Wisner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Hemorrhage from Right Common Carotid Artery, Post Operative</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epidermoid Carcinoma of Epiglottis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1-2 Minutes</b> <b>2-3 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 6, 1959</b> to <b>April 23, 1959</b> , that I last saw the deceased alive on <b>April 23, 1959</b> , and that death occurred at <b>6:07 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/24/59</b> ACTUAL SIGNATURE <b>John S. Dillon</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>JOHN S. DILLON, M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>4/28/59</b>		<b>Cedar Hill</b>		<b>Seatons md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co, Inc 517 1/2 St SE</b>				24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BACCHARD 10

<p>1. Name of Deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of Birth</p>	
<p>5. Place of Birth</p>		<p>6. Date of Death</p>		<p>7. Time of Death</p>		<p>8. Place of Death</p>	
<p>9. Cause of Death</p>		<p>10. Manner of Death</p>		<p>11. Physician's Signature</p>		<p>12. Registrar's Signature</p>	
<p>13. Date of Burial</p>		<p>14. Place of Burial</p>		<p>15. Burial Officer's Signature</p>		<p>16. Date of Entry</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4573

## CERTIFICATE OF DEATH

04548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue</u>		c. LENGTH OF STAY IN 1b <u>4 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLOTTE</u> First Middle Last		4. DATE OF DEATH <u>APRIL</u> Month Day Year <u>7</u> 19 <u>59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>91 Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Bingham Gentle</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Margaret Lowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>I Hardin</u>	
17. INFORMANT <u>2903 Burton Hill Rd</u>		Address <u>md, Rainier</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA (KIDNEY FAILURE)</u> DUE TO <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>260x</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 9, 1959</u> , to <u>APRIL 7, 1959</u> , that I last saw the deceased alive on <u>APRIL 5</u> , 19 <u>59</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Spencer</u> M.D.		ADDRESS (Street, city or town, state) <u>Columbia Road</u> DATE SIGNED <u>Burtonville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John R. Spencer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>APR 10 '59</u>	
ADDRESS <u>Mt. Rainier Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hand</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN  
CONFIRMATION  
OF  
DEATH

11/18/1918

THE

11/18/1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04549  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>		d. STREET ADDRESS <u>1631 Euclid Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Leah</u> Middle <u>Carolyn</u> Last <u>Larsen</u>		4. DATE OF DEATH <u>4/13/59</u> Day <u>13</u> Month <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>13</u> Hours <u>1</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woodward &amp; Lothrop</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Lauritz H. G. Larsen</u>		14. MOTHER'S MAIDEN NAME <u>Anna Christensen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>47-13-59</u>	
17. INFORMANT <u>Dr. Christ</u>		Address <u>47-13-59</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Peptic Ulcer &amp; massive hemorrhage</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Carcinoma of kidney</u> (c) <u>Generalized arteriosclerosis &amp; aortic aneurysm (multiple)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>57</u> , to <u>4/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>59</u> , and that death occurred at <u>5:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5911 - 16th ST. N.W. Wash. DC</u> DATE SIGNED <u>4/14/59</u>			
ACTUAL SIGNATURE <u>Philip Bloemsma</u> M.D.		PHYSICIAN'S NAME (Type) <u>Philip Bloemsma</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/15/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>--</u>		22d. LOCATION (City, town, or county) (State) <u>Ridgeway, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04550  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
c. LENGTH OF STAY IN 1b <b>DOA</b>		d. STREET ADDRESS <b>8913 Kensington Parkway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ngok-oy</b> Middle <b>Hom</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>oriental</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1896</b>
9. AGE (in years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>China</b>	
11. BIRTHPLACE (State or foreign country) <b>China</b>		12. CITIZEN OF WHAT COUNTRY? <b>China</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>n 1530 1st. St. N.W., Allen Wong Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hanging</b> (a), stating the underlying cause lost. DUE TO (c) <b>974X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Found hanging by neck in bed room</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found hanging by neck in brd room of her home</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found hanging by neck in brd room of her home</b>	
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Found hanging by neck in brd room of her home</b>
20f. (City or town) <b>Washington, D.C.</b>		20g. (County) <b>D.C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. RURAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Park</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee</b>		ADDRESS <b>Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>APR 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

Item 18 Film 241 4-23-59ams

4575

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>monty</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1407 Wheaton Lane</i>				d. STREET ADDRESS <i>1407 Wheaton La</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Thomas John Lomax</i>				4. DATE OF DEATH Month Day Year <i>Apr 4 1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-24-1926</i>	9. AGE (In years last birthday) <i>32</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm E. Lomax</i>				14. MOTHER'S MAIDEN NAME <i>Estelle Rumphrey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wm E. Lomax</i> Address <i>Stu 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute alcoholism</i> <i>322.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>4-6-59</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/9/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>APR 9 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4576

Reg. Dist. No. 04552

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>2½ yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5037 BRADLEY BOULEVARD</b>				d. STREET ADDRESS <b>5037 BRADLEY BOULEVARD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>L.</b> Last <b>LOVELESS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 6, 1897</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST B. FOSTER</b>				14. MOTHER'S MAIDEN NAME <b>EFFIE V. DENNY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-34-8838</b>		17. INFORMANT <b>Mr. Charles F. Loveless, 5037 Bradley Blvd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				18. CAUSE OF DEATH (Continued) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Buska</b>				24a. REC'D BY REGISTRAR <b>APR 13 59</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4476

## CERTIFICATE OF DEATH

04553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				d. STREET ADDRESS <u>612 Northampton Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Kenneth MAIN</u>				4. DATE OF DEATH Month Day Year <u>APRIL 26 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 23 1959</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>3</u>		IF UNDER 24 HRS. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Charles MAIN</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jane Becker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u> Address <u>Same Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Apr 23, 1959</u> , to <u>Apr 26, 1959</u> , that I last saw the deceased alive on <u>Apr 26, 1959</u> , and that death occurred at <u>3:10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Lawrence Avery</u>				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave. Silver Spring Md</u>			
DATE SIGNED <u>4/26/59</u>							
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery, M.D.</u>				<u>10110 Georgia Ave. Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>4-27-59</u>		<u>Washington Sanatorium &amp; Hosp. Takoma PK, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Haege M.D.</u>				ADDRESS <u>Washington Sanatorium &amp; Hosp. Takoma PK, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

APR 28 '59

CERTIFICATE OF DEATH

1. DATE OF DEATH		2. TIME OF DEATH	
3. PLACE OF DEATH		4. COUNTY	
5. CITY		6. STATE	
7. SEX		8. AGE	
9. RACE		10. OCCUPATION	
11. MARITAL STATUS		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN	
15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DEATH CERTIFICATE		20. SIGNATURE OF DEATH CERTIFICATE	
21. SIGNATURE OF DEATH CERTIFICATE		22. SIGNATURE OF DEATH CERTIFICATE	
23. SIGNATURE OF DEATH CERTIFICATE		24. SIGNATURE OF DEATH CERTIFICATE	
25. SIGNATURE OF DEATH CERTIFICATE		26. SIGNATURE OF DEATH CERTIFICATE	
27. SIGNATURE OF DEATH CERTIFICATE		28. SIGNATURE OF DEATH CERTIFICATE	
29. SIGNATURE OF DEATH CERTIFICATE		30. SIGNATURE OF DEATH CERTIFICATE	
31. SIGNATURE OF DEATH CERTIFICATE		32. SIGNATURE OF DEATH CERTIFICATE	
33. SIGNATURE OF DEATH CERTIFICATE		34. SIGNATURE OF DEATH CERTIFICATE	
35. SIGNATURE OF DEATH CERTIFICATE		36. SIGNATURE OF DEATH CERTIFICATE	
37. SIGNATURE OF DEATH CERTIFICATE		38. SIGNATURE OF DEATH CERTIFICATE	
39. SIGNATURE OF DEATH CERTIFICATE		40. SIGNATURE OF DEATH CERTIFICATE	
41. SIGNATURE OF DEATH CERTIFICATE		42. SIGNATURE OF DEATH CERTIFICATE	
43. SIGNATURE OF DEATH CERTIFICATE		44. SIGNATURE OF DEATH CERTIFICATE	
45. SIGNATURE OF DEATH CERTIFICATE		46. SIGNATURE OF DEATH CERTIFICATE	
47. SIGNATURE OF DEATH CERTIFICATE		48. SIGNATURE OF DEATH CERTIFICATE	
49. SIGNATURE OF DEATH CERTIFICATE		50. SIGNATURE OF DEATH CERTIFICATE	
51. SIGNATURE OF DEATH CERTIFICATE		52. SIGNATURE OF DEATH CERTIFICATE	
53. SIGNATURE OF DEATH CERTIFICATE		54. SIGNATURE OF DEATH CERTIFICATE	
55. SIGNATURE OF DEATH CERTIFICATE		56. SIGNATURE OF DEATH CERTIFICATE	
57. SIGNATURE OF DEATH CERTIFICATE		58. SIGNATURE OF DEATH CERTIFICATE	
59. SIGNATURE OF DEATH CERTIFICATE		60. SIGNATURE OF DEATH CERTIFICATE	
61. SIGNATURE OF DEATH CERTIFICATE		62. SIGNATURE OF DEATH CERTIFICATE	
63. SIGNATURE OF DEATH CERTIFICATE		64. SIGNATURE OF DEATH CERTIFICATE	
65. SIGNATURE OF DEATH CERTIFICATE		66. SIGNATURE OF DEATH CERTIFICATE	
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69. SIGNATURE OF DEATH CERTIFICATE		70. SIGNATURE OF DEATH CERTIFICATE	
71. SIGNATURE OF DEATH CERTIFICATE		72. SIGNATURE OF DEATH CERTIFICATE	
73. SIGNATURE OF DEATH CERTIFICATE		74. SIGNATURE OF DEATH CERTIFICATE	
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79. SIGNATURE OF DEATH CERTIFICATE		80. SIGNATURE OF DEATH CERTIFICATE	
81. SIGNATURE OF DEATH CERTIFICATE		82. SIGNATURE OF DEATH CERTIFICATE	
83. SIGNATURE OF DEATH CERTIFICATE		84. SIGNATURE OF DEATH CERTIFICATE	
85. SIGNATURE OF DEATH CERTIFICATE		86. SIGNATURE OF DEATH CERTIFICATE	
87. SIGNATURE OF DEATH CERTIFICATE		88. SIGNATURE OF DEATH CERTIFICATE	
89. SIGNATURE OF DEATH CERTIFICATE		90. SIGNATURE OF DEATH CERTIFICATE	
91. SIGNATURE OF DEATH CERTIFICATE		92. SIGNATURE OF DEATH CERTIFICATE	
93. SIGNATURE OF DEATH CERTIFICATE		94. SIGNATURE OF DEATH CERTIFICATE	
95. SIGNATURE OF DEATH CERTIFICATE		96. SIGNATURE OF DEATH CERTIFICATE	
97. SIGNATURE OF DEATH CERTIFICATE		98. SIGNATURE OF DEATH CERTIFICATE	
99. SIGNATURE OF DEATH CERTIFICATE		100. SIGNATURE OF DEATH CERTIFICATE	

CHESTER COUNTY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4577 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04554  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elney</u>		c. LENGTH OF STAY IN 1b <u>10 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julius L. Mathews</u>		4. DATE OF DEATH <u>Apr 9 1959</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-1919</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Walter Mathews</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Newman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louise Mathews (wife)</u>		Address <u>Itun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis &amp; abdominal hemorrhage</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest &amp; abdomen</u> DUE TO (c) <u>auto accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in truck involved in head-on collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:45 4/9 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>Collierville Montg md</u>	
21. I certify that I took charge of the remains described above, held on autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>		22b. DATE THEREOF <u>4/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Frank</u>	





CERTIFICATE OF DEATH

Reg. Dist. No. 04555

4578

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>LOUDON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Poolesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taylor's Town</b> <b>Lucketts Post Office 83x-3</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence of Mr. T.B. Dorsett</b>		d. STREET ADDRESS <b>--</b>	
3. NAME OF DECEASED (Type or print) <b>RUSSELL</b> First <b>NAYLOR</b> Middle <b>McALISTER</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/1901</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Architectural</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Service Engineer</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John McAlister</b>		14. MOTHER'S MAIDEN NAME <b>Annie Naylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <b>Suzie D. McAlister</b> Address <b>Taylor's Town, Va. Lucketts Post Office</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150x Bronchopneumonia</b> DUE TO (b) <b>Carcinoma of BRONCHI Secondary</b> DUE TO (c) <b>Carcinoma of esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>aneurysm of abdominal aorta</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 months</b> <b>1 year</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 19</b> 19 <b>59</b> , to <b>APRIL 27</b> 19 <b>59</b> that I last saw the deceased alive on <b>april 25</b> 19 <b>59</b> , and that death occurred at <b>11:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DAWSONVILLE</b> DATE SIGNED ACTUAL SIGNATURE <b>John G. Fawcett</b> M.D. <b>P.O. Boyd, Md</b> PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Episcopal</b>	22d. LOCATION (City, town, or county) (State) <b>Forestville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 29 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4477

## CERTIFICATE OF DEATH

Reg. Dist. No. 04556

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San and Hospital</u>				1d. STREET ADDRESS <u>111 Maple Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>Le Roy</u> Last <u>McCATHRAN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6th</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/88</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James K. McCathran</u>				14. MOTHER'S MAIDEN NAME <u>Annie Belle Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerotic heart disease</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>April 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>59</u> , and that death occurred at <u>10:55</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>8257 Georgia Ave. Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>				DATE SIGNED <u>April 7 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Gaither</u>				ADDRESS <u>Gaithersburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Gaither</u>			



4579

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>602 E. Chase Apartments</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Rodney</b> Middle <b>Parnell</b> Last <b>McDevitt</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1957</b>				
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR Manths Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Robert McDevitt</b>		14. MOTHER'S MAIDEN NAME <b>Earline Griffin</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest in immediate post operative period</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Correction of ventricular septal defect, atrial septal defect &amp; pulmonic infundibular stenosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>March 22, 1959</b> , to <b>April 1, 1959</b> , that I last saw the deceased alive on <b>April 1, 1959</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/1/59</b> ACTUAL SIGNATURE <b>N. Perryman Collins</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>N. Perryman Collins, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/59</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>W.W. Chambers Co 1400 Chapin St. NW Wash, D.C.</b>		22d. LOCATION (City, town, or county) (State) <b>Columbus, Ga.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '59</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Birth		Place of Birth		Usual Residence	
Jan 1, 1887		Maryland		Baltimore, Md.	
Cause of Death		Manner of Death		Place of Death	
Heart Disease		Natural		Home	
Date of Death		Time of Death		Physician	
April 1, 1932		10:30 AM		Dr. J. H. Smith	
Signature of Physician		Signature of Registrar		Signature of Deceased	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	



4478

CERTIFICATE OF DEATH

04558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>		d. STREET ADDRESS <u>18800 Plymouth St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Frank Meacomes</u>		4. DATE OF DEATH Month Day Year <u>4 15 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-15-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-BARBER</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>Bryant H. Meacomes</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Eaton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-03-8473</u>	
17. INFORMANT <u>Mrs. Rosa D. Meacomes, wife</u>		Address <u>Records 8800 Plymouth St. Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>48</u> , to <u>APRIL</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>14 APRIL</u> , 19 <u>59</u> , and that death occurred at <u>10<sup>30</sup> A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>LBSnow</u>		DATE SIGNED <u>4/15/59</u>	
PHYSICIAN'S NAME (Type) <u>L. B. SNOW</u>		ADDRESS (Street, city or town, state) <u>7950 N. H. AVE. LANGLEY PARK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>		24. REC'D BY REGISTRAR <u>APR 20 '59</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0722481 7-244-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4479

## CERTIFICATE OF DEATH

04559  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>17</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7420 Maple Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>-</u> Last <u>MEYERS</u>				4. DATE OF DEATH <u>Apr. 15</u> 19 <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 10, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Serie</u>		14. MOTHER'S MAIDEN NAME <u>Louise Mohelis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Edward M Meyers, 7410 Maple Ave. T.P. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Heart Failure</u> 434.1 DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>104 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 20</u> , 19 <u>59</u> , to <u>15</u> <u>Apr</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>15 April</u> , 19 <u>59</u> , and that death occurred at <u>10:25</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Y. B. Queen</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7112 Willow Ave</u>			
PHYSICIAN'S NAME (Type) <u>Y. B. Queen</u>				ADDRESS <u>Jakoma Park Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St NW DC.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1900"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Dec 10, 1945"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint number, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and is to be filed in the office of the Registrar of the State Department of Health. It is to be used for the purpose of determining the cause of death and for the purpose of determining the manner of death. It is to be filled out in duplicate and one copy is to be retained in the office of the Registrar and the other copy is to be sent to the office of the State Department of Health.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04560  
Reg. Dist. No. 215

FOR STATE  
HEALTH DEPT.

4580

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>5017 Sheriff Road, N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anthony Xavier MILLER</b>			4. DATE OF DEATH Month Day Year <b>April 6 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-34</b>	9. AGE (In years last b'day) <b>24 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Servie</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Edward MILLER</b>			14. MOTHER'S MAIDEN NAME <b>Lillian BASKERVILLE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Unknown Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Contusion brain</b> DUE TO (c) <b>Airplane crash</b>					INTERVAL BETWEEN ONSET AND DEATH <b>14½ hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Crewmember in airplane which crashed and burnt on landing</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>11:30 a.m.</b> <b>4-5 1959</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Naval Air Station</b>	
20f. (City or town) <b>Patuxent, St. Marys, Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-7-59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Snowden</b> Snowden Funeral Home, Rockville, Md.		24a. REC'D BY REGISTRAR <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a permit-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.  $\left( \frac{1}{2} \right)^n$  (b)  $\left( \frac{1}{2} \right)^n$



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4480

## CERTIFICATE OF DEATH

Reg. Dist. No. **04561**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Nursing Home</u>		d. STREET ADDRESS <u>1805 Hegd Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eva</u> Middle <u>M</u> Last <u>Miller</u>		<b>6. DATE OF DEATH</b> Month <u>Apr</u> Day <u>23</u> Year <u>1959</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 10 1891</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>67</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Librarian Congress</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>clerk Retired U. Va.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. A</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>	
<b>13. FATHER'S NAME</b> <u>J. E. Burns</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mae Daniels</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Record of Cedar Haven Rest Home - Takoma Park Md</u>		<b>Address</b> <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>174X</u> DUE TO <u>Cerebral carcinoma of brain - metastasis - lung adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1944</u> <u>July 1957</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that I attended the deceased from</b> <u>9/20/1937</u> , to <u>4/23/1959</u> , that I last saw the deceased alive on <u>4/23/1959</u> , and that death occurred at <u>7:23 P.M.</u> from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <u>2030 Carroll Ave Takoma Park Md</u>			
<b>ACTUAL SIGNATURE</b> <u>Howard T. Morse</u> M.D.		<b>DATE SIGNED</b> <u>  </u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>H. T. Morse M.D.</u>		<u>  </u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>		<b>22b. DATE THEREOF</b> <u>4-25-59</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Trinity Church</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Frederick Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Real Funeral Home</u>		<b>ADDRESS</b> <u>4812 Gaaden Rd</u>	
<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAY 1 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04562  
Reg. Dist. No.

4581

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN MCKNIGHT MILLER</b>		4. DATE OF DEATH <b>APRIL 24 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 27, 1912</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EXECUTIVE SECRETARY—AMERICAN TRUCKING ASS'N. VIRGINIA</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES MILLER</b>		14. MOTHER'S MAIDEN NAME <b>IONA BRADING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW #2</b>	
17. INFORMANT <b>MRS. MARIAN S. MILLER, 219 BADEN ST., SILVER SPR.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous Infarction - July 1953</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 24, 1948</b> , to <b>April 24, 1959</b> , that I last saw the deceased alive on <b>April 23, 1959</b> , and that death occurred at <b>4:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8248 GEORGIA AVE., SILVER SPRING</b> DATE SIGNED <b>4/24/59</b>			
ACTUAL SIGNATURE <b>Merrill M. Cross</b>		M.D. <b>8248 GEORGIA AVE., SILVER SPRING</b>	
PHYSICIAN'S NAME (Type) <b>MERRILL M. CROSS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 27, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PORT MYER, VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, INC.</b>		24a. REC'D BY REGISTRAR <b>APR 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hana</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Nov. 17, 1886*

5. Place of birth: *St. Louis, Mo.*

6. Date of death: *Dec. 10, 1931*

7. Place of death: *St. Louis, Mo.*

8. Cause of death: *Heart disease*

9. Signature of physician: *J. H. Smith*

10. Signature of registrar: *W. B. Jones*

11. Signature of undertaker: *W. B. Jones*

12. Signature of funeral home: *W. B. Jones*

13. Signature of cemetery: *W. B. Jones*

14. Signature of church: *W. B. Jones*

15. Signature of family: *W. B. Jones*

16. Signature of friends: *W. B. Jones*

17. Signature of neighbors: *W. B. Jones*

18. Signature of community: *W. B. Jones*

19. Signature of state: *W. B. Jones*

20. Signature of nation: *W. B. Jones*

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04563  
Reg. Dist. No.

4582

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2311 Dummie Ave</u>				d. STREET ADDRESS <u>2311 Dummie Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sharon Jane Miller</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-1959</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>14</u> Days <u>14</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Melvin E. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Knoke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Melvin Miller (father)</u>		Address <u>Blum 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of stomach contents</u> (c) <u>Upper Resp. Infection</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-30-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: ☐ Natural ☐ Accidental ☐ Suicidal ☐ Homicidal ☐ Undetermined

12. Signature of Medical Examiner: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Signature of Registrar: \_\_\_\_\_

15. Signature of Physician: \_\_\_\_\_

16. Signature of Nurse: \_\_\_\_\_

17. Signature of Family: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Signature of Other: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

25. Signature of Other: \_\_\_\_\_

26. Signature of Other: \_\_\_\_\_

27. Signature of Other: \_\_\_\_\_

28. Signature of Other: \_\_\_\_\_

29. Signature of Other: \_\_\_\_\_

30. Signature of Other: \_\_\_\_\_

31. Signature of Other: \_\_\_\_\_

32. Signature of Other: \_\_\_\_\_

33. Signature of Other: \_\_\_\_\_

34. Signature of Other: \_\_\_\_\_

35. Signature of Other: \_\_\_\_\_

36. Signature of Other: \_\_\_\_\_

37. Signature of Other: \_\_\_\_\_

38. Signature of Other: \_\_\_\_\_

39. Signature of Other: \_\_\_\_\_

40. Signature of Other: \_\_\_\_\_

41. Signature of Other: \_\_\_\_\_

42. Signature of Other: \_\_\_\_\_

43. Signature of Other: \_\_\_\_\_

44. Signature of Other: \_\_\_\_\_

45. Signature of Other: \_\_\_\_\_

46. Signature of Other: \_\_\_\_\_

47. Signature of Other: \_\_\_\_\_

48. Signature of Other: \_\_\_\_\_

49. Signature of Other: \_\_\_\_\_

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04564  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>9 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2217 HENDERSON AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>DAVID</u> Last <u>MILLER SR</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27</u> <u>AUG. 22 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICK CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MILLER, EDWARD.</u>		14. MOTHER'S MAIDEN NAME <u>unknown LAMBERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>MRS. LUCY CALLAWAY</u>		Address <u>same as above.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>GENERAL ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>URINARY TRACT INFECTION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>JULY 4 1958</u> , to <u>APRIL 14 1957</u> , that I last saw the deceased alive on <u>APRIL 14 1957</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVENUE</u> DATE SIGNED <u>APRIL 14 1957</u>			
ACTUAL SIGNATURE <u>James A. Roberts</u>		M.D. <u>8907 GEORGIA AVENUE</u> <u>APRIL 14 1957</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		<u>SILVER SPRING, MARYLAND.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Reynold E. Pumphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

VS A15 (4)  
15M 9/86



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04565  
Reg. Dist. No.

4584

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY in lb <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13529 Grenoble Dr</u>				e. STREET ADDRESS <u>13529 Grenoble Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Glenn A.</u> Middle <u>Mills</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>apr</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Je</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-1908</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>n. s. gro.</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. a</u>	
13. FATHER'S NAME <u>Hyman Link</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Strauss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No, no, unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Morton A. Mills</u>		Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> 12 yr							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>13 yr</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>4-4-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Sons-3501 14th St., N.W.</u>				24a. REC'D BY REGISTRAR <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thau</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Signature of Registrar: \_\_\_\_\_

15. Signature of Physician: \_\_\_\_\_

16. Signature of Nurse: \_\_\_\_\_

17. Signature of Undertaker: \_\_\_\_\_

18. Signature of Burial Place: \_\_\_\_\_

19. Signature of Funeral Home: \_\_\_\_\_

20. Signature of Cemetery: \_\_\_\_\_

21. Signature of Interment: \_\_\_\_\_

22. Signature of Burial: \_\_\_\_\_

23. Signature of Cremation: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04566

Reg. Dist. No.

4585

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>1 Rt. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Virginia</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Williams</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lambert</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Alice Dolly, Rt. 1 Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial asthma</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLASZCZAK</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alvin L. Maclean</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

DATE SIGNED  
4-25-59

FOR STATE  
HOSPITALS

DEPARTMENT OF HEALTH - BATHING, 18

TO BE FILLED IN BY THE  
STATE HOSPITAL

DATE OF DEATH

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BE FILLED IN

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WILLIAM H. HARRIS, M.D.  
STATE HOSPITAL

STATE HOSPITAL



4586

CERTIFICATE OF DEATH

04567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8403 Woodcliff</i>		d. STREET ADDRESS <i>8403 Woodcliff Court</i>	
3. NAME OF DECEASED (Type or print) <i>Maggie May Monred</i>		4. DATE OF DEATH <i>April 9 1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept-9-1873</i>
9. AGE (in years less birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR <i>7</i> Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house keeping at home</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Washington, D. C.</i>	
13. FATHER'S NAME <i>Charles Davis</i>		14. MOTHER'S MAIDEN NAME <i>Catherine E Trail</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Ravenell A. Monred</i>		18. ADDRESS <i>8403 Woodcliff Court Silver Spring, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lungs</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2-3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-1-1939</i> to <i>4-9-1959</i> , that I last saw the deceased alive on <i>4-8-1959</i> , and that death occurred at <i>3:40 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7-Brooks Avenue Gaithersburg, Md.</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		DATE SIGNED <i>—</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-11-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>	22d. LOCATION (City, town, or county) (State) <i>Gaithersburg Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel G. Gartner</i>		ADDRESS <i>Gaithersburg Md.</i>	
24a. REC'D BY REGISTRAR <i>APR 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED William C. Miller		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1-1-1874		PLACE OF BIRTH St. Louis, Mo.	
OCCUPATION Miner		EDUCATION High School		MARRIAGE Married		RELIGION Methodist		DATE OF MARRIAGE 1-1-1898		PLACE OF MARRIAGE St. Louis, Mo.	
CAUSE OF DEATH Pneumonia		PERIOD OF ILLNESS 2 weeks		DATE OF DEATH 1-1-1919		PLACE OF DEATH St. Louis, Mo.		DATE OF BURIAL 1-3-1919		PLACE OF BURIAL St. Louis, Mo.	
SIGNATURE OF PHYSICIAN J. B. ...		SIGNATURE OF MINISTER ...		SIGNATURE OF CORONER ...		SIGNATURE OF WITNESS ...		SIGNATURE OF WITNESS ...		SIGNATURE OF WITNESS ...	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4587 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04568

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5468 Wisconsin Ave</u>				d. STREET ADDRESS <u>5468 Wisconsin Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Gabriel</u> Last <u>Mooney</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1891</u>		9. AGE (in years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tourist Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Cecilia Mooney (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>suicide</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>April 28-57</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammy Bue</u>				ADDRESS <u>1661- Capital Ave NE</u>		24a. REC'D BY REGISTRAR <u>APR 30 57</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. E. Evans</u>	



4588

## CERTIFICATE OF DEATH

04569

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Alabama</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>15 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. STREET ADDRESS <b>Route #3</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Woodrow Anson Moore</b>			4. DATE OF DEATH Month Day Year <b>April 13, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1912</b>		9. AGE (In years last birthday) <b>46 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>	11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Woodward Moore</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Estes</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>424-26-1222</b>	17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation and cardiac arrest</b> <b>465X</b> DUE TO <b>Post operative surgical repair of atrial septal defect and total anomalous venous return</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Massive thrombosis of left pulmonary artery</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic renal disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>Months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 29, 1959</b> , to <b>April 13, 1959</b> , that I last saw the deceased alive on <b>April 13, 1959</b> , and that death occurred at <b>3:35 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert D. Bloodwell</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>4-14-59</b>	
PHYSICIAN'S NAME (Type) <b>Robert D. Bloodwell, M. D.</b>		National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>--</b>	
22d. LOCATION (City, town, or county) (State) <b>Winfield, Alabama</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Faint text]</p>		<p>AGE                  [Faint text]</p>	
<p>SEX                  [Faint text]</p>		<p>RACE                  [Faint text]</p>	
<p>DATE OF BIRTH                  [Faint text]</p>		<p>DATE OF DEATH                  [Faint text]</p>	
<p>PLACE OF BIRTH                  [Faint text]</p>		<p>PLACE OF DEATH                  [Faint text]</p>	
<p>CAUSE OF DEATH                  [Faint text]</p>		<p>MANNER OF DEATH                  [Faint text]</p>	
<p>DATE OF INTERMENT                  [Faint text]</p>		<p>PLACE OF INTERMENT                  [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>SIGNATURE OF REGISTRAR                  [Faint text]</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4481

## CERTIFICATE OF DEATH

04570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b Approx 4 hrs. 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 1 10,810 BLOSSOM LANE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD EDGAR MOREHOUSE				4. DATE OF DEATH Month Day Year APRIL 25 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/1/85	
				9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (retired)				10b. KIND OF BUSINESS OR INDUSTRY Optical Co.		11. BIRTHPLACE (State or foreign country) VERMONT	
13. FATHER'S NAME CHARLES MOREHOUSE				14. MOTHER'S MAIDEN NAME JENNIE SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 019-09-4799		17. INFORMANT Address Mr. Harold E. Morehouse, 10,810 Blossom Lane Silver Spring, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular collapse 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - acute coronary occlusion DUE TO (c) - arteriosclerotic heart disease 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Massive pulmonary embolism				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 56, 19, to 4-24, 19 59, that I last saw the deceased alive on 4-24, 19 59, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE (Veronica Troost) M.D. 10236 N. H. Ave. Silver Spring							
PHYSICIAN'S NAME (Type) VERONICA TROOST 4-25-1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/28/59		22c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON COUNTY, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Jiska.				24a. REC'D BY REGISTRAR DATE APR 28 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF SKIN White		9. COLOR OF HAIR Brown		10. COLOR OF EYES Blue	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH April 4, 1968		15. TIME OF DEATH 2:01 PM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESSES J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF FUNERAL HOME J. Edgar Hoover	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF CHIEF OF BUREAU J. Edgar Hoover		24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU J. Edgar Hoover		25. SIGNATURE OF DEPUTY CHIEF OF BUREAU J. Edgar Hoover	

4589

CERTIFICATE OF DEATH

Reg. Dist. No.

04571

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Beach Park</b> 04X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>411 Belton Road</b>				d. STREET ADDRESS <b>North Beach Park</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mildred Elizabeth Morrison</b>				4. DATE OF DEATH Month Day Year <b>April 28, 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/17/1903</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>George W. Robeson</b>				14. MOTHER'S MAIDEN NAME <b>Florence I. Glick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Theodore Morrison-411 Belton Rd., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b> <b>2 months</b> <b>---</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, and Hypertension</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 4,</b> 19 <b>59</b> , to <b>4-28-</b> 19 <b>59</b> , that I last saw the deceased alive on <b>4-21-</b> 19 <b>59</b> , and that death occurred at <b>11:20 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8829 Flower Avenue, Silver Spring, Md.</b>							
ACTUAL SIGNATURE <b>Samuel A. Hillman</b>				PHYSICIAN'S NAME (Type) <b>Samuel A. Hillman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

CERTIFICATE OF DEATH

1228

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 10, 1918		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Pneumonia		8. DISEASE OR INJURY Pneumonia		9. PREVIOUS ILLNESS None	
10. OCCASION OF DEATH Sudden		11. PLACE OF BIRTH Maryland		12. DATE OF BIRTH April 10, 1853	
13. NAME OF MOTHER Mary Harris		14. NAME OF FATHER John Harris		15. NAME OF SPOUSE Elizabeth Harris	
16. NAME OF REGISTRAR J. H. Harris		17. SIGNATURE OF REGISTRAR (Signature)		18. SIGNATURE OF DECEASED (Signature)	
19. NAME OF WITNESS J. H. Harris		20. SIGNATURE OF WITNESS (Signature)		21. NAME OF WITNESS J. H. Harris	
22. SIGNATURE OF WITNESS (Signature)		23. NAME OF WITNESS J. H. Harris		24. SIGNATURE OF WITNESS (Signature)	
25. NAME OF WITNESS J. H. Harris		26. SIGNATURE OF WITNESS (Signature)		27. NAME OF WITNESS J. H. Harris	
28. SIGNATURE OF WITNESS (Signature)		29. NAME OF WITNESS J. H. Harris		30. SIGNATURE OF WITNESS (Signature)	
31. NAME OF WITNESS J. H. Harris		32. SIGNATURE OF WITNESS (Signature)		33. NAME OF WITNESS J. H. Harris	
34. SIGNATURE OF WITNESS (Signature)		35. NAME OF WITNESS J. H. Harris		36. SIGNATURE OF WITNESS (Signature)	
37. NAME OF WITNESS J. H. Harris		38. SIGNATURE OF WITNESS (Signature)		39. NAME OF WITNESS J. H. Harris	
40. SIGNATURE OF WITNESS (Signature)		41. NAME OF WITNESS J. H. Harris		42. SIGNATURE OF WITNESS (Signature)	
43. NAME OF WITNESS J. H. Harris		44. SIGNATURE OF WITNESS (Signature)		45. NAME OF WITNESS J. H. Harris	
46. SIGNATURE OF WITNESS (Signature)		47. NAME OF WITNESS J. H. Harris		48. SIGNATURE OF WITNESS (Signature)	
49. NAME OF WITNESS J. H. Harris		50. SIGNATURE OF WITNESS (Signature)		51. NAME OF WITNESS J. H. Harris	
52. SIGNATURE OF WITNESS (Signature)		53. NAME OF WITNESS J. H. Harris		54. SIGNATURE OF WITNESS (Signature)	
55. NAME OF WITNESS J. H. Harris		56. SIGNATURE OF WITNESS (Signature)		57. NAME OF WITNESS J. H. Harris	
58. SIGNATURE OF WITNESS (Signature)		59. NAME OF WITNESS J. H. Harris		60. SIGNATURE OF WITNESS (Signature)	
61. NAME OF WITNESS J. H. Harris		62. SIGNATURE OF WITNESS (Signature)		63. NAME OF WITNESS J. H. Harris	
64. SIGNATURE OF WITNESS (Signature)		65. NAME OF WITNESS J. H. Harris		66. SIGNATURE OF WITNESS (Signature)	
67. NAME OF WITNESS J. H. Harris		68. SIGNATURE OF WITNESS (Signature)		69. NAME OF WITNESS J. H. Harris	
70. SIGNATURE OF WITNESS (Signature)		71. NAME OF WITNESS J. H. Harris		72. SIGNATURE OF WITNESS (Signature)	
73. NAME OF WITNESS J. H. Harris		74. SIGNATURE OF WITNESS (Signature)		75. NAME OF WITNESS J. H. Harris	
76. SIGNATURE OF WITNESS (Signature)		77. NAME OF WITNESS J. H. Harris		78. SIGNATURE OF WITNESS (Signature)	
79. NAME OF WITNESS J. H. Harris		80. SIGNATURE OF WITNESS (Signature)		81. NAME OF WITNESS J. H. Harris	
82. SIGNATURE OF WITNESS (Signature)		83. NAME OF WITNESS J. H. Harris		84. SIGNATURE OF WITNESS (Signature)	
85. NAME OF WITNESS J. H. Harris		86. SIGNATURE OF WITNESS (Signature)		87. NAME OF WITNESS J. H. Harris	
88. SIGNATURE OF WITNESS (Signature)		89. NAME OF WITNESS J. H. Harris		90. SIGNATURE OF WITNESS (Signature)	
91. NAME OF WITNESS J. H. Harris		92. SIGNATURE OF WITNESS (Signature)		93. NAME OF WITNESS J. H. Harris	
94. SIGNATURE OF WITNESS (Signature)		95. NAME OF WITNESS J. H. Harris		96. SIGNATURE OF WITNESS (Signature)	
97. NAME OF WITNESS J. H. Harris		98. SIGNATURE OF WITNESS (Signature)		99. NAME OF WITNESS J. H. Harris	
100. SIGNATURE OF WITNESS (Signature)		101. NAME OF WITNESS J. H. Harris		102. SIGNATURE OF WITNESS (Signature)	

## CERTIFICATE OF DEATH

04572

Reg. Dist. No.

4590

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WASHINGTON D.C. GLEN MAR PARK, Md.</u>	
		d. STREET ADDRESS <u>5810 AUGUSTA LANE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHRYN GRABER MORROW</u>		4. DATE OF DEATH Month Day Year <u>4 21 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/02</u>
9. AGE (In years last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTORS OFFICE ASSIST.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dr. J. CONNER</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RENNALD VICTOR GRABER</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ADELE PREUSS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1915-1917</u>		16. SOCIAL SECURITY NO. <u>1915-1917</u>	
17. INFORMANT (LOIS M. L.) <u>KATHERINE L. SHANKS</u>		Address <u>BETH., Md. 6500 WINNEPEG RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary thrombosis.</u> <u>466X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of the lt external iliac vein.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>April 21</u> , 1959, that I last saw the deceased alive on <u>April 20</u> , 1959, and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW Wash D.C.</u>	
DATE SIGNED <u>4/21/59</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chuan Funeral Home</u>		ADDRESS <u>3703 Wynn Dr. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>APR 23 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4591

## CERTIFICATE OF DEATH

04573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Jacksonville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48X-3</b> d. STREET ADDRESS <b>2941 Arappahoe Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles</b> First <b>Exum</b> Middle <b>Murray</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 8, 1934</b> 9. AGE (In years last birthday) <b>24</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Estimator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence G. Murray</b>		14. MOTHER'S MAIDEN NAME <b>Nora Spivey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cryptococcal meningitis</b> DUE TO <b>134.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Hodgkins Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 13, 1959</b> , to <b>April 17, 1959</b> , that I last saw the deceased alive on <b>April 17, 1959</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-18-59</b>			
ACTUAL SIGNATURE <b>George M. Owen</b> PHYSICIAN'S NAME (Type) <b>George M. Owen, M. D.</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit</b>		22b. DATE THEREOF <b>4/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Jacksonville, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hana</b>	

CERTIFICATE OF DEATH

Name of Deceased Robert A. Thompson		Date of Birth 1/10/50	
Sex Male		Race White	
Date of Death 1/10/50		Place of Death Baltimore, Maryland	
Cause of Death (To be filled by physician)		Manner of Death (To be filled by physician)	
Signature of Physician (To be filled by physician)		Signature of Registrar (To be filled by registrar)	
Name of Hospital or Institution (To be filled by physician)		Name of City or Town (To be filled by registrar)	
Name of County (To be filled by registrar)		Name of State (To be filled by registrar)	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4592

## CERTIFICATE OF DEATH

04574

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b> 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Richard</b> Last <b>Nicholson</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 26, 1868</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>21</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Thomas Nicholson</b>				14. MOTHER'S MAIDEN NAME <b>(unknown) Antonia Pickins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>		17. INFORMANT <b>Russell Nicholson-421 Delafeild Pl. N. W. Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c) <b>Arterio Sclerotic</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/1/59</b> , 19 <b>59</b> , to <b>4/19/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/1/59</b> , 19 <b>59</b> , and that death occurred at <b>10:20pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b> DATE SIGNED <b>4/20/59</b> ACTUAL SIGNATURE <b>JMB</b> M.D. <b>Sandy Spring</b> PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Darnestown Church</b>		22d. LOCATION (City, town, or county) (State) <b>Darnestown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4593

## CERTIFICATE OF DEATH

04575

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47x-3</b> d. STREET ADDRESS <b>Apt. 502</b> <b>2122 Massachusetts Ave., NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Fabian</b> Middle <b>Peter</b> Last <b>NOEL</b>				4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-82</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Xavier NOEL</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. CLUNK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1/20/09 to May 1915</b>			
17. INFORMANT <b>(B) Norman Noel, 934 Bardswell Rd., Baltimore, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary sclerosis, marked with recanalized thrombus, lt. ant, descending coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Myocardial fibrosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Vascular Accident</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 30</b> , 19 <b>59</b> , to <b>April 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>59</b> , and that death occurred at <b>7:03P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-11-59</b>							
ACTUAL SIGNATURE <b>Robert C. Thomas</b>				M.D. <b>U. S. Naval Hospital, NNMC</b>			
PHYSICIAN'S NAME (Type) <b>Robert C. THOMAS, LT, MC, USN</b>				<b>Bethesda 14, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawler's &amp; Sons, 1756 Penn. Ave. NW, Wash., DC</b>				24a. REC'D BY REGISTRAR <b>APR 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CITY

STATE

COUNTRY

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTRY

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PLACE OF DEATH

CITY

STATE

COUNTRY

RESIDENCE



4594

## CERTIFICATE OF DEATH

04576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 9 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>O'Connell</u> Last <u>O'Connell</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1893</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Cook</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Margaret Steiner</u>		18. ADDRESS <u>4533 Chesapeake St N.W. Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive heart failure with pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic - hypertensive heart disease</u> DUE TO (c) <u>5 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 18</u> , 1953, to <u>Apr 12</u> , 1959, that I last saw the deceased alive on <u>Apr 12</u> , 1959, and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Malcolm P. Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>4535 Yuma St N.W. Wash, D.C.</u> DATE SIGNED <u>4/12/59</u>	
PHYSICIAN'S NAME (Type) <u>MALCOLM P. HARRISON</u>		4535 Yuma St. N. W. 4/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>4/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Schenectady, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

05750

CERTIFICATE OF DEATH

1900

*[Faint, mostly illegible text, likely containing personal details of the deceased and medical information.]*



*[Faint text at the bottom of the page, possibly a signature line or official statement.]*

## Reg. Dist. No. 215

VS AIS (4)  
15M 10/57



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4596

## CERTIFICATE OF DEATH

04578  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MICHIGAN</u> b. COUNTY <u>ST. JOSEPH.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>7 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STURGIS</u> <u>59X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1418 HIGHLAND DRIVE</u>				d. STREET ADDRESS <u>RFD #3</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>ALMIRA (MYRA) D. PALMER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>APRIL 28 1959.</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JAN. 14, 1894</u>		9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>GEORGE DINGMAN</u>			
14. MOTHER'S MAIDEN NAME <u>BELLE RICHMOND</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE.</u>			
16. SOCIAL SECURITY NO. <u>NONE.</u>				17. INFORMANT <u>MRS. WYNAFRED BOWMAN</u> <u>1418 HIGHLAND DRIVE SILVER SPRING, MONTGOMERY</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA MEDIASTINUM</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA BREAST.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>NONE.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) (County) (State) _____		21. I certify that I attended the deceased from <u>MARCH 5, 1959</u> , to <u>APRIL 28, 1959</u> , that I last saw the deceased alive on <u>APRIL 28, 1959</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8907 GEORGIA AVENUE 4/28/59</u>					
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		<u>SILVER SPRING, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL 5/2/59</u>		22b. DATE THEREOF <u>5/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>			
22d. LOCATION (City, town, or county) (State) <u>PARKERSBURG, IOWA</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond H. Zula</u>					
24a. REC'D BY REGISTRAR DATE <u>MAY 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04258

RECORDS OF DEATH

1928





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 1c FilmG241 4-28-59 et  
**4597** **CERTIFICATE OF DEATH**

04579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>88 1/2</b> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Edward</b> Last <b>Peavornick</b>				4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 March 1918</b>	
9. AGE (In years last birthday) yrs. <b>41</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Peavornick</b>				14. MOTHER'S MAIDEN NAME <b>Anna Valenick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>193-10-3799</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-cerebellar hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myelogenous leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>months</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>January 20, 19 59</b> to <b>April 18, 19 59</b> , that I last saw the deceased alive on <b>April 18, 19 59</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leonard Garren</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-18-59</b>			
PHYSICIAN'S NAME (Type) <b>Leonard Garren, M. D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Point Marion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Yanette County, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. Humphrey</b>				ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INVESTIGATED STATE DEPARTMENT OF HEALTH - BALTIMORE 10

INVESTIGATED STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of investigator: _____</p>	
<p>9. Signature of registrar: _____</p>	
<p>10. Signature of coroner: _____</p>	
<p>11. Signature of medical examiner: _____</p>	
<p>12. Signature of funeral director: _____</p>	
<p>13. Signature of next of kin: _____</p>	
<p>14. Signature of witness: _____</p>	
<p>15. Signature of registrar: _____</p>	
<p>16. Signature of coroner: _____</p>	
<p>17. Signature of medical examiner: _____</p>	
<p>18. Signature of funeral director: _____</p>	
<p>19. Signature of next of kin: _____</p>	
<p>20. Signature of witness: _____</p>	
<p>21. Signature of registrar: _____</p>	
<p>22. Signature of coroner: _____</p>	
<p>23. Signature of medical examiner: _____</p>	
<p>24. Signature of funeral director: _____</p>	
<p>25. Signature of next of kin: _____</p>	
<p>26. Signature of witness: _____</p>	
<p>27. Signature of registrar: _____</p>	
<p>28. Signature of coroner: _____</p>	
<p>29. Signature of medical examiner: _____</p>	
<p>30. Signature of funeral director: _____</p>	
<p>31. Signature of next of kin: _____</p>	
<p>32. Signature of witness: _____</p>	
<p>33. Signature of registrar: _____</p>	
<p>34. Signature of coroner: _____</p>	
<p>35. Signature of medical examiner: _____</p>	
<p>36. Signature of funeral director: _____</p>	
<p>37. Signature of next of kin: _____</p>	
<p>38. Signature of witness: _____</p>	
<p>39. Signature of registrar: _____</p>	
<p>40. Signature of coroner: _____</p>	
<p>41. Signature of medical examiner: _____</p>	
<p>42. Signature of funeral director: _____</p>	
<p>43. Signature of next of kin: _____</p>	
<p>44. Signature of witness: _____</p>	
<p>45. Signature of registrar: _____</p>	
<p>46. Signature of coroner: _____</p>	
<p>47. Signature of medical examiner: _____</p>	
<p>48. Signature of funeral director: _____</p>	
<p>49. Signature of next of kin: _____</p>	
<p>50. Signature of witness: _____</p>	
<p>51. Signature of registrar: _____</p>	
<p>52. Signature of coroner: _____</p>	
<p>53. Signature of medical examiner: _____</p>	
<p>54. Signature of funeral director: _____</p>	
<p>55. Signature of next of kin: _____</p>	
<p>56. Signature of witness: _____</p>	
<p>57. Signature of registrar: _____</p>	
<p>58. Signature of coroner: _____</p>	
<p>59. Signature of medical examiner: _____</p>	
<p>60. Signature of funeral director: _____</p>	
<p>61. Signature of next of kin: _____</p>	
<p>62. Signature of witness: _____</p>	
<p>63. Signature of registrar: _____</p>	
<p>64. Signature of coroner: _____</p>	
<p>65. Signature of medical examiner: _____</p>	
<p>66. Signature of funeral director: _____</p>	
<p>67. Signature of next of kin: _____</p>	
<p>68. Signature of witness: _____</p>	
<p>69. Signature of registrar: _____</p>	
<p>70. Signature of coroner: _____</p>	
<p>71. Signature of medical examiner: _____</p>	
<p>72. Signature of funeral director: _____</p>	
<p>73. Signature of next of kin: _____</p>	
<p>74. Signature of witness: _____</p>	
<p>75. Signature of registrar: _____</p>	
<p>76. Signature of coroner: _____</p>	
<p>77. Signature of medical examiner: _____</p>	
<p>78. Signature of funeral director: _____</p>	
<p>79. Signature of next of kin: _____</p>	
<p>80. Signature of witness: _____</p>	
<p>81. Signature of registrar: _____</p>	
<p>82. Signature of coroner: _____</p>	
<p>83. Signature of medical examiner: _____</p>	
<p>84. Signature of funeral director: _____</p>	
<p>85. Signature of next of kin: _____</p>	
<p>86. Signature of witness: _____</p>	
<p>87. Signature of registrar: _____</p>	
<p>88. Signature of coroner: _____</p>	
<p>89. Signature of medical examiner: _____</p>	
<p>90. Signature of funeral director: _____</p>	
<p>91. Signature of next of kin: _____</p>	
<p>92. Signature of witness: _____</p>	
<p>93. Signature of registrar: _____</p>	
<p>94. Signature of coroner: _____</p>	
<p>95. Signature of medical examiner: _____</p>	
<p>96. Signature of funeral director: _____</p>	
<p>97. Signature of next of kin: _____</p>	
<p>98. Signature of witness: _____</p>	
<p>99. Signature of registrar: _____</p>	
<p>100. Signature of coroner: _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4598

## CERTIFICATE OF DEATH

04580

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>5017 Aurora Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katherine Mary PIERUCKI</b>		4. DATE OF DEATH Month Day Year <b>April 30 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-29-59</b>
9. AGE (In years last birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ervin J. PIERUCKI</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Louise TELLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO (b) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 29</b> , 19 <b>59</b> , to <b>April 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>59</b> , and that death occurred at <b>8:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, NNMCMAY 5 1959</b>			
ACTUAL SIGNATURE <b>H. L. Walton</b> M.D. <b>U. S. Naval Hospital, NNMCMAY 5 1959</b> PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b> ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. S. K. K. K.</b>			

2051383XVO



4599

CERTIFICATE OF DEATH

04581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Conn.</u> b. COUNTY <u>New Haven</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Haven</u> 45X-3			
c. LENGTH OF STAY IN 1b <u>10 1/2 hours</u>				d. STREET ADDRESS <u>120 Dwight Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Louise Pond</u>				4. DATE OF DEATH Month Day Year <u>April 7, 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Kassel Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S.A.</u>			
13. FATHER'S NAME <u>Andrew Hafner</u>				14. MOTHER'S MARDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>m. Allen Pond, 7813 moorland road, Bethesda, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u> DUE TO (b) <u>Ruptured Myocardial Infarction Posterior</u> DUE TO (c) <u>Thrombosis Left Circumflex Coronary Artery</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>10 hours</u> <u>10 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 7, 1959</u> to <u>April 7, 1959</u> that I last saw the deceased alive on <u>April 7, 1959</u> , and that death occurred at <u>3:52 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savarese, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane - Bethesda</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Savarese, Jr., 4890 Battery Lane, Bethesda, Md.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. Bur.</u>		22b. DATE THEREOF <u>4/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Waterburg, Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

MEDICAL CERTIFICATION

Order Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

W. J. C. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04582

4600

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN It <b>20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>121 Pennsylvania Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Edwin</b> Last <b>Powers</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1957</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Donald F. Powers</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Pearl Barnhart</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia due to Pseudomonas</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 Weeks</b> DUE TO <b>587.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cystic Fibrosis of Pancreas</b> <b>20 Months</b> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 21</b> , 19 <b>59</b> , to <b>April 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>59</b> , and that death occurred at <b>8:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-10-59</b> ACTUAL SIGNATURE <b>Leon G. Smith</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Leon G. Smith, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St Paul's Washington Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Shreve</b>				ADDRESS <b>Hancock Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Race _____		Birth Date _____	
Place of Birth _____		Date of Birth _____	
Usual Residence _____		Date of Death _____	
Cause of Death _____		Date of Death _____	
Place of Death _____		Date of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G241 4-30-59 et

4482

## CERTIFICATE OF DEATH

04583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>7412 Carroll Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Estelle</u> Last <u>Prescott</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-79</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.N.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Orndorff</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Terval</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Washington San. &amp; Hosp.</u>		Address <u>Tak. PK, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (p), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Congestive failure &amp; Rt. Hydrothorax</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>years</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14</u> , 1959, to <u>4/24</u> , 1959, that I last saw the deceased alive on <u>4/24</u> , 1959, and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas H WOLOTON</u>		ADDRESS (Street, city or town, state) <u>300 Underwood</u>	
PHYSICIAN'S NAME (Type) <u>Chas H WOLOTON</u>		DATE SIGNED <u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Walters</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04584

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>4483</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>77 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N. Carolina</b> b. COUNTY <b>Raleigh</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>70x-3</b> d. STREET ADDRESS <b>905 Lake Boone Trail</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth Virginia Freudley</b> First Middle Last 4. DATE OF DEATH <b>4-20-59</b> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-08</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>George W. Fowler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah V. Grimes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>241 30 9390</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast tractation</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>170x</b> DUE TO (c) <b>170x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-6, 1959</b> , to <b>4-20, 1959</b> , that I last saw the deceased alive on <b>4-19, 1959</b> , and that death occurred at <b>5:27 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.W. DANISH</b>		ADDRESS (Street, city or town, state) <b>927 PERSHING DR. SILVER SPRING, MD</b>	
PHYSICIAN'S NAME (Type) <b>A.W. DANISH</b>		DATE SIGNED <b>4-20-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Don. Welch</b>		24a. REC'D BY REGISTRAR <b>APR 23 '59</b>	
ADDRESS <b>2224 Wisconsin Ave. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

30-2013-16



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4601

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

04585

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>P.O. Box 432, RFD #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mildred Lee PUCKETT</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-31-59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		9. AGE (In years last birthday) yrs. <b>1</b> IF UNDER 1 YEAR Months <b>1</b> Dpys <b>1</b> IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Maynard L. PUCKETT</b>				14. MOTHER'S MAIDEN NAME <b>Priscilla PERRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b> Address <b>---</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity + Immaturity</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>---</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 31</b> , 19 <b>59</b> , to <b>April 1</b> , 19 <b>59</b> , that I lost the deceased on <b>April 1</b> , 19 <b>59</b> , and that death occurred at <b>4:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-2-59</b>							
ACTUAL SIGNATURE <b>H. L. Walton</b> M.D. <b>U. S. Naval Hospital, NNMC</b>				DATE SIGNED <b>4-2-59</b>			
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b>				ADDRESS <b>Bethesda 14, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>4-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>UNKNOWN</b>		22d. LOCATION (City, town, or county) (State) <b>UNKNOWN Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumpfrey</b> ADDRESS <b>Funeral Home, Bethesda, Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HAYES		45		M		W		JAN 10 1901	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		JAN 10 1901		BALTIMORE, MD.		JAN 10 1901		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
J. H. HAYES		J. H. HAYES		J. H. HAYES		J. H. HAYES		J. H. HAYES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1901		JAN 10 1901		JAN 10 1901		JAN 10 1901		JAN 10 1901	

## CERTIFICATE OF DEATH

04586  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Mont. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>	d. STREET ADDRESS <u>5803 - Walton Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julia H. Purtle</u>		4. DATE OF DEATH <u>April 20</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	11. BIRTHPLACE (State or foreign country) <u>County Cork, Ireland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Sheehan</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Cashman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Thomas L. Purtle - 6 Brooks, de Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Bleeding</u> <u>153.8</u> DUE TO <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>18 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, general</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>June 22, 1953</u> to <u>April 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>59</u> , and that death occurred at <u>4:00 P.</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u>	
DATE SIGNED <u>4/20/59</u>		M.D. <u>5009 Del Ray Ave., Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>		5009 Del Ray Ave., Bethesda, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>4/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Stoneham, Mass.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

## CERTIFICATE OF DEATH

Reg. Dist. No. 04587

4603

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boysd-B.F.D.</b>		c. LENGTH OF STAY IN lb <b>3 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KENNETH MURPHY RAMSEUR</b>		4. DATE OF DEATH <b>April 18 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 18-1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Johns Hill Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Murphy Ramsey</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>238-07-1288</b>	
INFORMANT <b>Walter Ramsey, Raleigh, N.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Advanced arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Esophageal varicosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>June, 1956</b> , to <b>April 18, 1959</b> , that I last saw the deceased alive on <b>18 April, 1959</b> , and that death occurred at <b>12:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Fawcett</b>		DATE SIGNED <b>Dawsonville, Ga.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT</b>		ADDRESS (Street, city or town, state) <b>P.O. Box 101, Wad.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>4/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>	22d. LOCATION (City, town, or county) (State) <b>Lincolnton N.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Barnesville, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

CERTIFICATE OF ANALYSIS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04588  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>5 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Travilah Rd.</u>				d. STREET ADDRESS <u>1 Travilah Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie Elizabeth Beedy</u>				4. DATE OF DEATH Month Day Year <u>Apr. 11 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-11-1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. Madison</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Nussle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mary K. Beall (daughter)</u> Address <u>11 Park st Rockville md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 14</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W Barber</u>				24a. REC'D BY REGISTRAR <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Thane</u>	

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BP



1  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES W. HARRIS		45		M		W		JAN 15 1912		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		TITLE	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		J. W. HARRIS		M.D.	
PREVIOUS ILLNESS		HISTORY OF PRESENT ILLNESS		FINDINGS AT AUTOPSY		OPINION OF EXAMINER		SIGNATURE OF ATTENDING PHYSICIAN		TITLE	
NONE		SICK FOR SEVERAL DAYS		HEART DISEASE		NATURAL		J. W. HARRIS		M.D.	
DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE		SIGNATURE OF ATTENDING PHYSICIAN		TITLE	
JAN 15 1912		BALTIMORE, MD.		J. W. HARRIS		M.D.		J. W. HARRIS		M.D.	

4484

## CERTIFICATE OF DEATH

04589  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 16 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				d. STREET ADDRESS <u>17325 Baltimore Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Christian</u> Middle <u>E. Reichenbaugh</u> Last <u></u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/30/78</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Benedict Reichenbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Susanna Schopfner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Patient's hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilaterally</u> 443X DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular Disease</u> (c) <u>Years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Diabetes Mellitus (2) Carcinoma of Prostate</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 15, 1959</u> , to <u>April 7, 1959</u> , that I last saw the deceased alive on <u>April 7th, 1959</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7701 Carroll Avenue, Md.</u> DATE SIGNED <u>4/7/59</u>							
ACTUAL SIGNATURE <u>Wallace N. Mook</u>				PHYSICIAN'S NAME (Type) <u>Wallace N. Mook M.D. Takoma Park 12 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George W. M. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ridge Road - Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jakoma Funeral Home</u>				24a. REC'D BY REGISTRAR <u>APR 10 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04590

Reg. Dist. No.

4604

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> <b>Augusta</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stuarts Draft</b> <b>83x-3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Box 166</b>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>William</b> Last <b>Reno, Jr.</b>			4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 11, 1942</b>		9. AGE (In years last birthday) <b>17 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert W. Reno, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Ann Gann</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest at the time of surgery</b> <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital cyanotic heart disease with pseudotruncus arteriosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 8, 19 59</b> to <b>April 3, 19 59</b> that I last saw the deceased alive on <b>April 3, 19 59</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William P. Cornell</b>		M.D. <b>The Clinical Center</b>		ADDRESS (Street, city or town, state) <b>National Institutes of Health</b>		DATE SIGNED <b>4/3/59</b>	
PHYSICIAN'S NAME (Type) <b>William P. Cornell, M. D.</b>		<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 5/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CALVARY METHODIST CH. CEME</b>		22d. LOCATION (City, town, or county) (State) <b>STUARTS DRAFT, VIRGINIA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ives Funeral Home, Inc.</b>				ADDRESS <b>ARLINGTON, VA.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04591

Reg. Dist. No.

4605

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8035 Park Lane</u> d. STREET ADDRESS <u>Bethesda</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emma Louise Renshaw</u> First Middle Last <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 14, 1883</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>4. DATE OF DEATH</b> <u>April 14</u> 19 <u>59</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Samuel Renshaw</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Huddleson</u> <b>17. INFORMANT</b> <u>Sue M. Imirie (cousin)</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/></b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>4-14-59</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>4-17-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u> <b>22d. LOCATION (City, town, or county)</b> <u>Rockville, Maryland</u> <b>(State)</b> _____	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda 14, Md.</u> ADDRESS		<b>24a. REC'D BY REGISTRAR</b> <u>APR 17 '59</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-1-31

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

605

DATE OF DEATH  
11-1-31

TIME OF DEATH  
11:00 AM

PLACE OF DEATH  
HOME

TO BUREAU  
OF HEALTH

DATE OF DEATH  
11-1-31

PLACE OF DEATH  
HOME

NAME OF DECEASED  
JAMES J. Grosch

AGE  
40  
SEX  
M  
RACE  
W  
RELIGION  
C  
MARRIAGE  
M

CAUSE OF DEATH  
CORONARY THROMBOSIS  
MURDERED

PLACE OF DEATH  
HOME

DATE OF DEATH  
11-1-31

TIME OF DEATH  
11:00 AM

SIGNATURE OF EXAMINER  
Frank J. Grosch

DATE OF DEATH  
11-1-31

NAME OF DECEASED  
JAMES J. Grosch

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04592

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>			d. STREET ADDRESS <b>810 Sheridan Street, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>AMOS TUNKS ROBINSON</b>			4. DATE OF DEATH <b>April 18, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1901</b>		9. AGE (In years last birthday) <b>57</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer-U. S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James P. Robinson</b>			14. MOTHER'S MAIDEN NAME <b>Louise Tunks</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 &amp; 11 401-05-6951</b>	17. INFORMANT <b>Mrs Celeste Cox-4757 Chevy Chase Drive Bethesda, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J Broschart</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>4/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frankfort</b>		22d. LOCATION (City, town, or county) (State) <b>Frankfort, Kentucky</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

2008  
MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. HOME		2. PLACE OF DEATH b. HOSPITAL	
3. NAME OF DECEASED JAMES E. ROBINSON		4. NAME OF DECEASED JAMES E. ROBINSON	
5. SEX Male		6. SEX Male	
7. RACE White		8. RACE White	
9. BIRTH DATE Aug. 10, 1901		10. BIRTH DATE Aug. 10, 1901	
11. BIRTH PLACE U.S. Govt. Kentucky		12. BIRTH PLACE U.S. Govt. Kentucky	
13. OCCUPATION Printer		14. OCCUPATION Printer	
15. MARITAL STATUS Married		16. MARITAL STATUS Married	
17. NAME OF SPOUSE JAMES E. ROBINSON		18. NAME OF SPOUSE JAMES E. ROBINSON	
19. NAME OF CHILD JAMES E. ROBINSON		20. NAME OF CHILD JAMES E. ROBINSON	
21. NAME OF CHILD JAMES E. ROBINSON		22. NAME OF CHILD JAMES E. ROBINSON	
23. NAME OF CHILD JAMES E. ROBINSON		24. NAME OF CHILD JAMES E. ROBINSON	
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71. NAME OF CHILD JAMES E. ROBINSON		72. NAME OF CHILD JAMES E. ROBINSON	
73. NAME OF CHILD JAMES E. ROBINSON		74. NAME OF CHILD JAMES E. ROBINSON	
75. NAME OF CHILD JAMES E. ROBINSON		76. NAME OF CHILD JAMES E. ROBINSON	
77. NAME OF CHILD JAMES E. ROBINSON		78. NAME OF CHILD JAMES E. ROBINSON	
79. NAME OF CHILD JAMES E. ROBINSON		80. NAME OF CHILD JAMES E. ROBINSON	
81. NAME OF CHILD JAMES E. ROBINSON		82. NAME OF CHILD JAMES E. ROBINSON	
83. NAME OF CHILD JAMES E. ROBINSON		84. NAME OF CHILD JAMES E. ROBINSON	
85. NAME OF CHILD JAMES E. ROBINSON		86. NAME OF CHILD JAMES E. ROBINSON	
87. NAME OF CHILD JAMES E. ROBINSON		88. NAME OF CHILD JAMES E. ROBINSON	
89. NAME OF CHILD JAMES E. ROBINSON		90. NAME OF CHILD JAMES E. ROBINSON	
91. NAME OF CHILD JAMES E. ROBINSON		92. NAME OF CHILD JAMES E. ROBINSON	
93. NAME OF CHILD JAMES E. ROBINSON		94. NAME OF CHILD JAMES E. ROBINSON	
95. NAME OF CHILD JAMES E. ROBINSON		96. NAME OF CHILD JAMES E. ROBINSON	
97. NAME OF CHILD JAMES E. ROBINSON		98. NAME OF CHILD JAMES E. ROBINSON	
99. NAME OF CHILD JAMES E. ROBINSON		100. NAME OF CHILD JAMES E. ROBINSON	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04593

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10609 Bucknell Dr</u>				d. STREET ADDRESS <u>10609 Bucknell Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>Glen</u> Middle <u>Carson</u> Last <u>Russell</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>2</u> Min.	IF UNDER 24 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. union</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Kit C. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Hovey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Belle Russell (wife) Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u>		(County) <u>—</u> (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-9-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

FOR STATE  
HEALTH DEPT.



THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN AND FOUND TO BE IN GOOD HEALTH AND FIT TO SERVE IN THE ARMY.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. SMITH  
AGE: 35 SEX: M  
DATE OF DEATH: 10-15-1918  
PLACE OF DEATH: HOME  
CAUSE OF DEATH: HEPATIC FAILURE  
DISEASE OR INJURY: HEPATIC FAILURE  
MANNER OF DEATH: NATURAL  
SIGNATURE OF PHYSICIAN: J. J. SMITH  
DATE: 10-15-1918  
PLACE: BALTIMORE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04594

Reg. Dist. No.

4608

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN <u>1 wk</u>		d. STREET ADDRESS <u>802 Crothers Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3404 University Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Phillip Scherrer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1892</u>
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Printing Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Chas Scherrer</u>		14. MOTHER'S MAIDEN NAME <u>Christine Crehan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Drum F. Smith (daughter)</u>		Address <u>4411 Gros St Rockville md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Salivator heart disease</u> (c) <u></u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. McFalls Son Co. 300-4 St N.E.</u>		24. REC'D BY REGISTRAR <u>APR 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>	
DATE OF DEATH <i>Jan 15 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
RESIDENCE <i>1234 Main St</i>		OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocarditis</i>		SIGNATURE OF EXAMINER <i>Dr. J. H. Jones</i>	
LOCALITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Maryland</i>	
DATE OF EXAMINATION <i>Jan 16 1918</i>		TIME OF EXAMINATION <i>10:00 AM</i>		PLACE OF EXAMINATION <i>Home</i>	
SIGNATURE OF DECEASED <i>John J. Smith</i>		SIGNATURE OF NEXT OF KIN <i>John J. Smith</i>		SIGNATURE OF WITNESS <i>John J. Smith</i>	
SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. H. Jones</i>		SIGNATURE OF JURY <i>John J. Smith</i>		SIGNATURE OF JURY <i>John J. Smith</i>	

RECEIVED  
JAN 16 1918  
BALTIMORE

1090  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4609 CERTIFICATE OF DEATH

04595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Johnson's Nursing Home</b> <b>10737 Colesville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna C. Schvier</b>		4. DATE OF DEATH <b>April 22, 19 59</b>	
5. SEX <b>fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Clerk</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Times Herald</b>	
11c. BIRTHPLACE (State or foreign country) <b>Point of Rocks, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Benjamin Franklin Stouffer</b>		14. MOTHER'S MAIDEN NAME <b>Unobtainable</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-09-9753</b>	
17. INFORMANT <b>John W. Schvier</b>		Address <b>616 Powhatan Place, NW, Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis with Rt. hemiplegia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Hypertensive arteriosclerotic heart disease 2 yrs.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/29</b> , 19 <b>40</b> , to <b>4/22/</b> , 19 <b>59</b> that I last saw the deceased alive on <b>4/16/</b> , 19 <b>59</b> , and that death occurred at <b>8:30 A.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. C. Leonardo</b>		ADDRESS (Street, city or town, state) <b>5801-13th St. NW.</b> DATE SIGNED <b>4/24/59</b>	
PHYSICIAN'S NAME (Type) <b>A.C. Leonardo</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/25/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Episcopal</b>	22d. LOCATION (City, town, or county) (State) <b>Point of Rocks, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 17th St. N.W. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

6008

CERTIFICATE OF DEATH

STATE OF ILLINOIS

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing certificate, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Illinois

Witness my hand and seal of office this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Illinois

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04596

Reg. Dist. No.

4485

1. PLACE OF DEATH a. COUNTY <i>Montg</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>38 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7305 Willow Ave</i>				d. STREET ADDRESS <i>7305 Willow Ave</i>			
3. NAME OF DECEASED (Type or print) <i>George Loftus Scott</i>				4. DATE OF DEATH Month <i>apr</i> Day <i>24</i> Year <i>1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 5, 1889</i>	9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months <i>24</i> Days <i>24</i> Hours <i>19</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber - Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H. Scott</i>				14. MOTHER'S MAIDEN NAME <i>Jane Heddes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>W.W.I. 200</i>		17. INFORMANT <i>Mrs. Mary L. Schofield</i> Address <i>2623 Colston Rd. Chelmsford</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO <i>hanging</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hanging</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>few min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hung self by neck in basement of his home</i>					
20c. TIME OF INJURY Hour <i>19</i> a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. BROSCART</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/28/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Hester</i>				24a. REC'D BY REGISTRAR DATE <i>APR 27 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hester</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 7 files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO THE STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

1. Name of Deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of Birth: \_\_\_\_\_  
5. Place of Birth: \_\_\_\_\_  
6. Usual Residence: \_\_\_\_\_  
7. Cause of Death: \_\_\_\_\_  
8. Manner of Death: \_\_\_\_\_  
9. Signature of Medical Examiner: \_\_\_\_\_  
10. Date: \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4610

## CERTIFICATE OF DEATH

04597  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Potomac</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ropine Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NAPOLEON JOSEPH Sheltra</b>		4. DATE OF DEATH Month Day Year <b>April 3 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 29, 1889</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Perry, N.H.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Ulderic Sheltra</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Plourde</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>004-32-0983</b>	
17. INFORMANT <b>Stanton E. Sheltra-son-same as 2d</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>obstruction of trachea</b> DUE TO (c) <b>Bronchogenic Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 wk.</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A-S H D. E C H Z.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1, 1956</b> to <b>4/3/59</b> , that I last saw the deceased alive on <b>4/3/59</b> , and that death occurred at <b>5:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>4/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>		<b>Rockville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 4/6/59</b>		22b. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>	
22c. LOCATION (City, town, or county) <b>Biddeford, Maine</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 6 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

1919

CERTIFICATE OF DEATH

1919

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

COLOR

RELIGION

EDUCATION

PROFESSION

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVAILING DISEASE

DIAGNOSIS

TESTS

POST-MORTEM

REPORT

SIGNATURE

DATE

PLACE

REPORT

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>DISTRICT OF COLUMBIA</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON 47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belmont Sanatorium</i>		d. STREET ADDRESS <i>4333 VAN NESS ST. N.W.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Edna</i> Middle <i>B.</i> Last <i>Simpson</i>		4. DATE OF DEATH Month <i>4</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 25, 1878</i>
9. AGE (In years lost birthday) yrs. <i>80</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>/</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Ruffin Butler</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>MURRAY SIMPSON</i>		Address <i>5811 HILLBURN WAY MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerosis heart disease</i> DUE TO (c) <i>arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>1 year</i> <i>year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>cerebral thrombosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 15</i> , 19 <i>59</i> , to <i>Jan 15</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>April 15</i> , 19 <i>59</i> , and that death occurred at <i>12:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Marcel Foret M.D.</i> M.D.			
PHYSICIAN'S NAME (Type) <i>MARCEL J. FORET MD 1746 KJNW</i> <i>4/15/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>4-17-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>HOLLY WOOD</i>	22d. LOCATION (City, town, or county) (State) <i>RICHMOND VIRGINIA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joe. Paulin Son of Joe. D.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 20 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4612

## CERTIFICATE OF DEATH

04599

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>15 days</b>		d. STREET ADDRESS <b>9908 Ashburton Lane</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James Michael</b> Middle <b>Slack</b> Last <b>Slack</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1959</b>
9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Slack</b>		14. MOTHER'S MAIDEN NAME <b>Teresa Budner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Slack (father)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL Heart Disease - Hypertension</b> <b>754.1</b> DUE TO <b>left ventricle (slight), minimal atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>aortic valve, Patent ductus arteriosus</b> DUE TO <b>fractured ovula.</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> Month <b>Day</b> <b>Year</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-23</b> , <b>1959</b> , to <b>4-7</b> , <b>1959</b> , that I last saw the deceased alive on <b>4-6</b> , <b>1959</b> , and that death occurred at <b>7:30 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis J. Troendle</b> M.D.		ADDRESS (Street, city or town, state) <b>809 View Mill Rd Rockville, Md</b>	
PHYSICIAN'S NAME (Type) <b>Francis J. Troendle</b>		DATE SIGNED <b>4/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-8-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	22d. LOCATION (City, town, or county) <b>Silver Spring Md</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>APR 9 59</b> DATE	
ADDRESS <b>7557 Wisconsin Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

2074355XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 7 days. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4613 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04600

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Roscoe C. Smart</b>			4. DATE OF DEATH <b>April 18, 1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/8/1884</b>		9. AGE (In years, month, day) <b>74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>contractor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
13. FATHER'S NAME <b>Erin Smart</b>			14. MOTHER'S MAIDEN NAME <b>Abbie</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hosp. Record</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>916.0</b> DUE TO <b>1st, 2nd and third degree burns involving neck trunk</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and upper extremities</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothes caught afire while burning trash in back yard at home</b>			
20c. TIME OF INJURY Month, Day, Year <b>11:40 a.m. 4/17 19 59</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
		20f. (City or town) <b>Silver Spring</b>		(County) <b>Montg.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>4/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Prince George County, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		ADDRESS <b>254 Carroll St NW. DC.</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MEDICAL CERTIFICATION

15

2

074



4614

## CERTIFICATE OF DEATH

04601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/59</u>
9. AGE (In years lost birthday) _____ yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>44</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>JAMES R. Smith</u>		14. MOTHER'S MAIDEN NAME <u>PATRICIA DUNN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Father James Robert Smith</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia (Immature prematurity)</u> DUE TO <u>761.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature separation of placenta</u> DUE TO (c) <u>Circumvallate placenta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>? 1-2 days</u> <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 4, 1959</u> , to <u>April 4, 1959</u> , that I last saw the deceased alive on <u>April 4, 1959</u> , and that death occurred at <u>5 a.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>W. Colliton, Jr.</u>		M.D. <u>Medical Bldg., Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. Colliton, Jr., Medical Bldg., Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fouse</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074252XVO

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED <i>Robert James Smith</i>		DATE OF DEATH <i>April 1, 1952</i>	
PLACE OF DEATH <i>Home</i>		CITY OF DEATH <i>Baltimore</i>	
AGE OF DECEASED <i>47</i>		SEX <i>Male</i>	
RACE <i>White</i>		MARRIED <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
OCCUPATION <i>None</i>		EDUCATION <i>High School</i>	
BIRTH DATE <i>April 1, 1905</i>		BIRTH PLACE <i>Baltimore, Md.</i>	
FATHER'S NAME <i>James Smith</i>		MOTHER'S NAME <i>Elizabeth Smith</i>	
PREVIOUS ILLNESS <i>None</i>		CAUSE OF DEATH <i>Heart Disease</i>	
IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>	
FUNDAMENTAL CAUSE <i>Arteriosclerosis</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE <i>April 1, 1952</i>		PLACE <i>Baltimore, Md.</i>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4615

## CERTIFICATE OF DEATH

04602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>3 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buckeystown</u> <u>RURAL</u> <u>10 X - 2</u> ✓		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Marion</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>6</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19, 1864</u>		9. AGE (In years last birthday) yrs. <u>95</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Grafton B. Crist</u>				14. MOTHER'S MAIDEN NAME <u>Emily J. Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Asbury Methodist Home, Gaithersburg, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X central vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>paroxysmal tachycardia</u> DUE TO (c) <u>pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-20</u> , 19 <u>57</u> , to <u>4-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>59</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D. <u>10128 Cedar Lane</u> <u>Hensington, Md.</u>				ADDRESS (Street, city or town, state)		DATE SIGNED <u>4-5-59</u>	
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Sheppard</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

Page 101, 102

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Signature of registrar</p>	
<p>13. Signature of registrar</p>		<p>14. Signature of registrar</p>	
<p>15. Signature of registrar</p>		<p>16. Signature of registrar</p>	
<p>17. Signature of registrar</p>		<p>18. Signature of registrar</p>	
<p>19. Signature of registrar</p>		<p>20. Signature of registrar</p>	
<p>21. Signature of registrar</p>		<p>22. Signature of registrar</p>	
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<p>71. Signature of registrar</p>		<p>72. Signature of registrar</p>	
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<p>75. Signature of registrar</p>		<p>76. Signature of registrar</p>	
<p>77. Signature of registrar</p>		<p>78. Signature of registrar</p>	
<p>79. Signature of registrar</p>		<p>80. Signature of registrar</p>	
<p>81. Signature of registrar</p>		<p>82. Signature of registrar</p>	
<p>83. Signature of registrar</p>		<p>84. Signature of registrar</p>	
<p>85. Signature of registrar</p>		<p>86. Signature of registrar</p>	
<p>87. Signature of registrar</p>		<p>88. Signature of registrar</p>	
<p>89. Signature of registrar</p>		<p>90. Signature of registrar</p>	
<p>91. Signature of registrar</p>		<p>92. Signature of registrar</p>	
<p>93. Signature of registrar</p>		<p>94. Signature of registrar</p>	
<p>95. Signature of registrar</p>		<p>96. Signature of registrar</p>	
<p>97. Signature of registrar</p>		<p>98. Signature of registrar</p>	
<p>99. Signature of registrar</p>		<p>100. Signature of registrar</p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>	c. LENGTH OF STAY IN 1b <b>10 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11.10.01</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		9. AGE (In years last birthday) yrs. <b>57</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>George H. Smith</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jemima Whetzel</b>	
16. SOCIAL SECURITY NO. <b>218 30 3544</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas</b> DUE TO <b>157x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Metastasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>157x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 mos</b> <b>6 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/6/59</b> , 19 <b>59</b> , to <b>4/16/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/15/59</b> , 19 <b>59</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b> DATE SIGNED <b>4/16/59</b>			
ACTUAL SIGNATURE <b>J. W. Bird</b> M.D. <b>Sandy Spring</b>		PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D., Sandy Spring, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 18</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes, Lutheran</b>	22d. LOCATION (City, town, or county) (State) <b>Redland Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W Barber</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04604  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>159 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>2310 Ashmeade Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Harold</b> Middle <b>Eugene</b> Last <b>SNOW</b>		4. DATE OF DEATH		Month <b>April</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-8-89</b>	9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Eugene SNOW</b>				14. MOTHER'S MAIDEN NAME <b>Julie ROMING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>7/1/07 to 12/21</b>		17. INFORMANT Address <b>(W) Anita F. Snow, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, squamous cell, larynx</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>September 28</b> 19 <b>59</b> , to <b>April 5</b> 19 <b>59</b> , that I last saw the deceased alive on <b>April 4</b> 19 <b>59</b> , and that death occurred at <b>8:17A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>4-6-59</b>							
ACTUAL SIGNATURE <b>F. J. LINEHAN, JR.</b>		PHYSICIAN'S NAME (Type) <b>Bethesda, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. F. Birch Funeral Home, 3034 M St., NW, Wash, DC</b>				24a. REG'D BY REGISTRAR <b>APR 8 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kane</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4618  
CERTIFICATE OF DEATH04605  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3	
		d. STREET ADDRESS 3114 9th Road N.	
3. NAME OF DECEASED (Type or print) First Middle Last Helen Mary SOUTHERLAND		4. DATE OF DEATH Month Day Year April 8 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-73
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. CHAPMAN		14. MOTHER'S MAIDEN NAME Virginia ALEXANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (S) Thomas C. Southerland, same as #2 above	
17. INFORMANT Address Thomas C. Southerland, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (Thrombosis) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (generalized) DUE TO (c) 20 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Hypostatic pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 17, 1959, to April 8, 1959, that I last saw the deceased alive on April 7, 1959, and that death occurred at 1:02A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 4-8-59 ACTUAL SIGNATURE John Wood Davis M.D. PHYSICIAN'S NAME (Type) John Wood DAVIS, LT, MC, USN Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-59	
22c. NAME OF CEMETERY OR CREMATORY Pohick Church Cemetery		22d. LOCATION (City, town, or county) (State) Pohick, Fairfax Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd, Arlington, Va.		24a. REC'D BY REGISTRAR APR 10 1959	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of neighbors		24. Signature of community	
25. Signature of church		26. Signature of cemetery		27. Signature of funeral home		28. Signature of undertaker	
29. Signature of family		30. Signature of friends		31. Signature of neighbors		32. Signature of community	
33. Signature of school		34. Signature of employer		35. Signature of neighbors		36. Signature of community	
37. Signature of church		38. Signature of cemetery		39. Signature of funeral home		40. Signature of undertaker	
41. Signature of family		42. Signature of friends		43. Signature of neighbors		44. Signature of community	
45. Signature of school		46. Signature of employer		47. Signature of neighbors		48. Signature of community	
49. Signature of church		50. Signature of cemetery		51. Signature of funeral home		52. Signature of undertaker	
53. Signature of family		54. Signature of friends		55. Signature of neighbors		56. Signature of community	
57. Signature of school		58. Signature of employer		59. Signature of neighbors		60. Signature of community	
61. Signature of church		62. Signature of cemetery		63. Signature of funeral home		64. Signature of undertaker	
65. Signature of family		66. Signature of friends		67. Signature of neighbors		68. Signature of community	
69. Signature of school		70. Signature of employer		71. Signature of neighbors		72. Signature of community	
73. Signature of church		74. Signature of cemetery		75. Signature of funeral home		76. Signature of undertaker	
77. Signature of family		78. Signature of friends		79. Signature of neighbors		80. Signature of community	
81. Signature of school		82. Signature of employer		83. Signature of neighbors		84. Signature of community	
85. Signature of church		86. Signature of cemetery		87. Signature of funeral home		88. Signature of undertaker	
89. Signature of family		90. Signature of friends		91. Signature of neighbors		92. Signature of community	
93. Signature of school		94. Signature of employer		95. Signature of neighbors		96. Signature of community	
97. Signature of church		98. Signature of cemetery		99. Signature of funeral home		100. Signature of undertaker	

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 18



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	c. LENGTH OF STAY IN lb <b>6 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8409 10th AVENUE</b>		d. STREET ADDRESS <b>8409 10th AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>LOUIS (LUIGI) T. (A) SPADARO</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/94</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BARBER</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SALVATORE SPADARO</b>		14. MOTHER'S MAIDEN NAME <b>PAULO LAGANA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-01-1481</b>	
17. INFORMANT <b>Mrs. Theresa M. Spadaro,</b>		Address <b>8409 10th Avenue Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus for 10 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Md.</b>		22e. REC'D BY REGISTRAR DATE <b>APR 2 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond W. Ziska</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNHART 18  
LOCAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <u>JOHN J. BARNHART</u></p>	
<p>AGE: <u>45</u> YEARS</p>	
<p>SEX: <u>MALE</u></p>	
<p>DATE OF DEATH: <u>1918-11-15</u></p>	
<p>PLACE OF DEATH: <u>HOME</u></p>	
<p>CAUSE OF DEATH: <u>HEART DISEASE</u></p>	
<p>DIAGNOSIS: <u>MYOCARDIAL INFARCTION</u></p>	
<p>DATE OF EXAMINATION: <u>1918-11-15</u></p>	
<p>SIGNATURE OF EXAMINER: <u>[Signature]</u></p>	
<p>PRINTED NAME OF EXAMINER: <u>JOHN J. BARNHART</u></p>	
<p>ADDRESS OF EXAMINER: <u>123 MAIN ST, BOSTON, MASS.</u></p>	
<p>DATE OF EXPIRATION: <u>1919-11-15</u></p>	
<p>REMARKS: <u>DECEASED WAS FOUND DEAD IN HIS BED. NO OTHER CAUSE OF DEATH WAS APPARENT.</u></p>	
<p>SIGNATURE OF PHYSICIAN: <u>[Signature]</u></p>	
<p>PRINTED NAME OF PHYSICIAN: <u>JOHN J. BARNHART</u></p>	
<p>ADDRESS OF PHYSICIAN: <u>123 MAIN ST, BOSTON, MASS.</u></p>	
<p>DATE OF EXPIRATION: <u>1919-11-15</u></p>	
<p>REMARKS: <u>DECEASED WAS FOUND DEAD IN HIS BED. NO OTHER CAUSE OF DEATH WAS APPARENT.</u></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4620

## CERTIFICATE OF DEATH

04607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>6716 Selkirk Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Winston</b> Middle <b>Bryant</b> Last <b>Stephens, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 20, 1888</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>3</b> Min. <b>15</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Salesman</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Winston Stephens</b>		14. MOTHER'S MAIDEN NAME <b>Amy Gaston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic stenosis &amp; insufficiency, Mitral insufficiency</b> DUE TO (b) <b>Rheumatic Heart disease</b> DUE TO (c) <b>410X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1</b> , 19 <b>59</b> , to <b>April 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 5</b> , 19 <b>59</b> , and that death occurred at <b>9:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-6-59</b> ACTUAL SIGNATURE <b>John A. Oates, M.D.</b> PHYSICIAN'S NAME (Type) <b>John A. Oates, M. D.</b> NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4621 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monrovia - R-1</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monrovia R-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Burdum Rd - Mr. Damascus</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Michael Edward Stevens</i>		4. DATE OF DEATH Month Day Year <i>Apr 3 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 21 1943</i>
9. AGE (In years last birthday) <i>15 yrs.</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. DC</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Stevens</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Belle Hagerman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>--</i>		16. SOCIAL SECURITY NO. <i>--</i>	
17. INFORMANT <i>Georgia Stevens (mother)</i>		Address <i>Stur 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation</i> 835X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Strangulation</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture left mandible</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of tractor which upset + fell across neck + face</i>	
20c. TIME OF INJURY Month, Day, Year <i>9:30 am 4-3 1957</i>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>farm</i>	20f. (City or town) (County) (State) <i>Damascus monty md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/6/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Oliver L. Moleworth</i>		ADDRESS <i>Damascus, Md.</i>	
24a. REC'D BY REGISTRAR <i>APR 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

MEDICAL CERTIFICATION

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4622

CERTIFICATE OF DEATH

04609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>9724-53rd Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Clarence</i> Middle <i>A</i> Last <i>Taft</i>				4. DATE OF DEATH # <i>4</i> Month <i>April</i> Day <i>26</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5/20/83</i>		9. AGE (In years lost birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Isaac Taft</i>				14. MOTHER'S MAIDEN NAME <i>Emmeline Ketchum</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>Informant</i>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> 156.1 DUE TO <i>Invasive Carcinoma Liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>4 mos.</i> (c) <i>4 mos.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Apr 1</i> , 19 <i>59</i> , to <i>Apr 24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Apr 24</i> , 19 <i>59</i> , and that death occurred at <i>3:20 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert G. Jaylen</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Washington Clinic, Wash D.C. 4/26/59</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/28/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Calverton</i>		22d. LOCATION (City, town, or county) (State) <i>Calverton Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Carl P. Mann</i> ADDRESS <i>300 4th St N.E. Wash, D.C.</i>				24a. REC'D BY REGISTRAR <i>APR 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01600

CENTRAL BUREAU OF WEATHER

*[Faint, mostly illegible text, likely a weather report or official communication. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4623

## CERTIFICATE OF DEATH

04610  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>400 S. Abingdon St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Walter THOMAS</u>		4. DATE OF DEATH Month Day Year <u>April 17 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-36</u>	9. AGE (In years last birthday) <u>22</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Takoma, Washington</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Hunley E. THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>Emma DEAK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>553-46-6693</u>		17. INFORMANT (F) Capt. Hunley E. Thomas, USN, above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - Bilateral</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pulmonary edema</u> DUE TO (c) <u>Type under</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>April 9</u> , 19 <u>59</u> , to <u>April 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 17</u> , 19 <u>59</u> , and that death occurred at <u>10:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital, NMMC</u> DATE SIGNED <u>4-17-59</u>					
ACTUAL SIGNATURE <u>Jerome A. Gold</u>		M.D. <u>U. S. Naval Hospital, NMMC</u>			
PHYSICIAN'S NAME (Type) <u>Jerome A. GOLD, LT, MC, USN</u>		<u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Shipment</u>		22b. DATE THEREOF <u>4-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>	
22d. LOCATION (City, town, or county) <u>Pasadena</u>		(State) <u>California</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arllington Funeral Home, 3901 N. Fairfax Drive,</u>		ADDRESS <u>Arlington, Va.</u>		24a. REC'D BY REGISTRAR <u>APR 21 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4624

## CERTIFICATE OF DEATH

04611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>106 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>621 -14th Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle <b>Russell</b> Last <b>Thornton</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>	9. AGE (In years last birthday) <b>64</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Thornton</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 14, 1959</b> , to <b>April 30, 1959</b> , that I last saw the deceased alive on <b>April 30, 1959</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5-1-59</b> ACTUAL SIGNATURE <b>Leonard Garren</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Leonard Garren, M. D.</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5.5.59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. McGuire</b>		24a. REC'D BY REGISTRAR <b>MAY 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4625

## CERTIFICATE OF DEATH

04612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>112 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>✓</u> <u>Seat Pleasant</u> <u>16X-2</u>		d. STREET ADDRESS <u>601 64th Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Joseph</u> Last <u>Tomardy</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 21, 1923</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Training Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Weather Bureau</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Paul Tomardy</u>		14. MOTHER'S MAIDEN NAME <u>Bina Mulcherne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>577-26-9089</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Carcinoma, Metastases: Mediastinal</u> <u>162.1</u> DUE TO <u>Bone, Adrenal Glands and Liver.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>January 5, 1959</u> , to <u>April 27, 1959</u> , that I last saw the deceased alive on <u>April 27, 1959</u> , and that death occurred at <u>10:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Leonard Garren, M.D.</u>				The Clinical Center <u>4/27/59</u>			
PHYSICIAN'S NAME (Type) <u>LEONARD GARREN, M.D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold A. Haulon</u> ADDRESS <u>3831 14 Ave NW</u>				24a. REC'D BY REGISTRAR DATE <u>APR 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haulon</u>	

CERTIFICATE OF DEATH

WILLIAM BOWMAN

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Signature of Registrar		Signature of Medical Officer		Signature of Coroner	
WILLIAM BOWMAN		45		Male		White		1878		1923		New York		Heart Disease							
Residence		Occupation		Marital Status		Education		Religion		Usual Habits		Previous Illnesses		Mental Condition		Signature of Informant		Signature of Physician		Signature of Undertaker	
123 Main St.		Clerk		Married		High School		Catholic		Sobriety		None		Sound							
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister		Name of Undertaker		Name of Physician		Name of Coroner		Name of Registrar							
1923		New York		St. Paul's		Rev. J. Smith		J. Doe		Dr. J. Doe		Mr. J. Doe		Mr. J. Doe							

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04613

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

4626

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 4311 Albemarle Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First William		Middle Francis		Last TROY	
4. DATE OF DEATH		Month April		Day 7		Year 19 59	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-81	
9. AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel TROY		14. MOTHER'S MAIDEN NAME Maggie SULLIVAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT (S) John W. Troy, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Brain Syndrome (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1959, to April 7, 1959, that I last saw the deceased alive on April 7, 1959, and that death occurred at 5:55 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome A. Gold		M.D. U. S. Naval Hospital		ADDRESS (Street, city or town, state)		DATE SIGNED 4-8-59	
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN		Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Vol Funeral Home		ADDRESS De Vol Funeral Home, 2224 Wisc. Ave., NW, Wash, DC		24a. REC'D BY REGISTRAR APR 10 59		24b. REGISTRAR'S SIGNATURE C. J. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4627

## CERTIFICATE OF DEATH

04614

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>29 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>702 Highland Dr.</i>	
3. NAME OF DECEASED (Type or print) <i>Helen</i> First <i>Carroll</i> Middle <i>Stull</i> Last <i>Woods</i>		4. DATE OF DEATH <i>April 3</i> 1959	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 27-1893</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frederick L. Grafflin</i>		14. MOTHER'S MAIDEN NAME <i>Molly Skinner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-14-1918A</i>	
17. INFORMANT <i>Hospital Records and Family</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr. 3-</i> , 1959, to <i>Apr. 3-</i> , 1959, that I last saw the deceased alive on <i>Apr. 3-</i> , 1959, and that death occurred at <i>2:30</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>AM Bin</i>		ADDRESS (Street, city or town, state) <i>Sandy Spring</i> DATE SIGNED <i>4/8/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr 6/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart Moore</i>		23a. REC'D BY REGISTRAR <i>APR 6 '59</i>	
ADDRESS <i>108 W York Baltimore</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

WILLIAM EXODID

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF UNDERTAKER

NAME OF CEMETERY

NAME OF CHURCH

NAME OF SOCIETY

NAME OF ORDER

NAME OF LODGE

NAME OF GUILD

NAME OF ASSOCIATION

NAME OF CLUB

NAME OF SOCIETY

NAME OF ORDER

NAME OF LODGE

NAME OF GUILD

NAME OF ASSOCIATION

NAME OF CLUB

NAME OF SOCIETY

NAME OF ORDER

NAME OF LODGE

NAME OF GUILD

NAME OF ASSOCIATION

NAME OF CLUB

NAME OF SOCIETY

NAME OF ORDER

NAME OF LODGE

NAME OF GUILD

NAME OF ASSOCIATION

NAME OF CLUB



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4628

## CERTIFICATE OF DEATH

04615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanatorium</u>		d. STREET ADDRESS <u>1955 Seminary Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J</u> Last <u>Turner</u> SR.		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1874</u>
9. AGE (In years last birthday) <u>84</u> Yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>	11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>		13. FATHER'S NAME <u>Alfred A. Turner</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Elizabeth Howles</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Miss Elizabeth A. Turner, 1955 Seminary Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>hemiplegic vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO <u>hypertension</u> (c) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>none</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 27, 1959</u> to <u>April 25, 1959</u> , that I last saw the deceased alive on <u>April 20, 1959</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u>		DATE SIGNED <u>April 25, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOHN S. ROGERS</u>		ADDRESS (Street, city or town, state) <u>1955 Seminary Rd. Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04616

Reg. Dist. No.

4486

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville,</b> d. STREET ADDRESS <b>Pindell School Road,</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Van Vliet</b>		4. DATE OF DEATH Month Day Year <b>April 4, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1959</b>
9. AGE (In years last birthday) yrs. <b>45</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Robert Thomas Van Vliet</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Lucille Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>father</b>	
17. INFORMANT <b>father</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital malformation -</b> <b>750x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anencephalus</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>48 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 4, 1959</b> , to <b>April 4, 1959</b> , that I last saw the deceased alive on <b>April 4, 1959</b> , and that death occurred at <b>6:45 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Sydney Leventhal, M. D. 9210 Colesville Rd. Silver Spring, Md. 4/4/59</b>			
ACTUAL SIGNATURE <b>Sydney Leventhal</b>		PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M. D. 9210 Colesville Rd. Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Takoma Park, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		24a. REC'D BY REGISTRAR <b>Washington Sanitarium and Hosp.</b>	
24b. REGISTRAR'S SIGNATURE <b>Takoma Park, Maryland</b>		APR 6 '59	

CERTIFICATE OF DEATH

1922

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

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RELIGION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CERTIFICATE OF DEATH

04617  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 das. 18 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>10707 Bucknell Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>D.</b> Last <b>Van Wagner</b>				4. DATE OF DEATH Month <b>4</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/94</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Davis</b>				14. MOTHER'S MAIDEN NAME <b>Laura Lawson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT Address <b>Marshall Banta Van Wagner, Jr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>1. Bacterial pneumonia. 2. Postoperative disease. 3. Bacteria</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>31 March, 1959</b> , to <b>3 April, 1959</b> , that I last saw the deceased alive on <b>2 April, 1959</b> , and that death occurred at <b>8:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Marshall T. Kimble</b> M.D. <b>929 Pershing Drive, S.E., Wash. D.C. 20037</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>SERUCH T. KIMBLE</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/7/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CLERGY		16. SIGNATURE OF OTHER	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF SURVIVORS		20. SIGNATURE OF OTHER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF SURVIVORS		24. SIGNATURE OF OTHER	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF SURVIVORS		28. SIGNATURE OF OTHER	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN		31. SIGNATURE OF SURVIVORS		32. SIGNATURE OF OTHER	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF SURVIVORS		36. SIGNATURE OF OTHER	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF SURVIVORS		40. SIGNATURE OF OTHER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF SURVIVORS		44. SIGNATURE OF OTHER	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF SURVIVORS		48. SIGNATURE OF OTHER	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF SURVIVORS		52. SIGNATURE OF OTHER	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF SURVIVORS		56. SIGNATURE OF OTHER	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF SURVIVORS		60. SIGNATURE OF OTHER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF SURVIVORS		64. SIGNATURE OF OTHER	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF SURVIVORS		68. SIGNATURE OF OTHER	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN		71. SIGNATURE OF SURVIVORS		72. SIGNATURE OF OTHER	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF SURVIVORS		76. SIGNATURE OF OTHER	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF NEXT OF KIN		79. SIGNATURE OF SURVIVORS		80. SIGNATURE OF OTHER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF SURVIVORS		84. SIGNATURE OF OTHER	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF SURVIVORS		88. SIGNATURE OF OTHER	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF SURVIVORS		92. SIGNATURE OF OTHER	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF NEXT OF KIN		95. SIGNATURE OF SURVIVORS		96. SIGNATURE OF OTHER	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF SURVIVORS		100. SIGNATURE OF OTHER	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18



4630

## CERTIFICATE OF DEATH

04618  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5408 Lambeth Rd.</b>		d. STREET ADDRESS <b>5408 Lambeth Road</b>	
3. NAME OF DECEASED (Type or print) <b>ZULA</b> First Middle <b>W.</b> Last <b>WARD</b>		4. DATE OF DEATH <b>April 17 1959</b> Month Day Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/2/1871</b>
9. AGE <b>88</b> years less <b>88</b> days		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALBERT WALKER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN MARKLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. LOUISE W. HASKIN, DAUGHTER</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>782.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Infarct</b> (c) <b>Cardiac Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> <b>24 hrs.</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1950</b> to <b>4/17, 1959</b> , that I last saw the deceased alive on <b>4/16, 1959</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Y. Jagers, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>5707 Wisconsin Ave., N.W. DC</b> DATE SIGNED <b>4/17/59</b>	
PHYSICIAN'S NAME (Type) <b>FRANK Y. JAGGERS, JR.</b>		<b>5707 Wisconsin Ave., N.W., D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawlers Sons, Wash. C, D.C.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>APR 20 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4631

## CERTIFICATE OF DEATH

04619  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>4453 B Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leroy</b> Middle <b>Alan</b> Last <b>Washington</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 2, 1905</b> 9. AGE (In years last birthday) yrs. <b>53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Washington</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Springs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>579-05-3309</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lutetic Aortic Valvulitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 26</b> , 19 <b>59</b> , to <b>April 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 23</b> , 19 <b>59</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/23/59</b> ACTUAL SIGNATURE <b>John Oates</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>John Oates, M. D.</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Stewart</b>		ADDRESS <b>30 H Street, N.E.</b>	
24a. REC'D BY REGISTRAR <b>APR 27 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thayer</b>	

U.S.A.

PAID

PAID BOND

CERTIFICATE OF DEATH

STATE OF MARYLAND

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## CERTIFICATE OF DEATH

04620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>District of Col.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>1915 Calvert St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Genevieve</u> Middle <u>E.</u> Last <u>Waters</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-?</u>
9. AGE (In years last birthday) <u>80?</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shela Waters</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mae Garr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Nicent B. Waters</u>		Address <u>5103 Ch. Ch. Pkwy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 450.0 DUE TO <u>Anterior wall Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture Hip (L)</u> (c) <u>Typhoid</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/27/58</u> , 19 to <u>4/26/59</u> , 19, that I last saw the deceased alive on <u>4/25/59</u> , 19, and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sam Allen, M.D.</u>		ADDRESS (Street, city or town, state) <u>Kensington, Md.</u> DATE SIGNED <u>4/26/59</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL ALLEN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Humberis Lewis</u>		ADDRESS <u>1756 R Ave NW</u>	
24a. REC'D BY REGISTRAR <u>APR 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

MADE IN THE U.S.A.  
OK FOR EXPORT  
F. J. WILKINS  
REC'D  
JAN 10 1934

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1888</i>	
5. PLACE OF BIRTH <i>Worcester, Mass.</i>		6. OCCUPATION <i>Engineer</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>	
11. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		12. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
13. SIGNATURE OF DECEASED <i>John J. Smith</i>		14. SIGNATURE OF DECEASED <i>John J. Smith</i>	
15. SIGNATURE OF DECEASED <i>John J. Smith</i>		16. SIGNATURE OF DECEASED <i>John J. Smith</i>	
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31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF DECEASED <i>John J. Smith</i>	
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51. SIGNATURE OF DECEASED <i>John J. Smith</i>		52. SIGNATURE OF DECEASED <i>John J. Smith</i>	
53. SIGNATURE OF DECEASED <i>John J. Smith</i>		54. SIGNATURE OF DECEASED <i>John J. Smith</i>	
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71. SIGNATURE OF DECEASED <i>John J. Smith</i>		72. SIGNATURE OF DECEASED <i>John J. Smith</i>	
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77. SIGNATURE OF DECEASED <i>John J. Smith</i>		78. SIGNATURE OF DECEASED <i>John J. Smith</i>	
79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF DECEASED <i>John J. Smith</i>	
81. SIGNATURE OF DECEASED <i>John J. Smith</i>		82. SIGNATURE OF DECEASED <i>John J. Smith</i>	
83. SIGNATURE OF DECEASED <i>John J. Smith</i>		84. SIGNATURE OF DECEASED <i>John J. Smith</i>	
85. SIGNATURE OF DECEASED <i>John J. Smith</i>		86. SIGNATURE OF DECEASED <i>John J. Smith</i>	
87. SIGNATURE OF DECEASED <i>John J. Smith</i>		88. SIGNATURE OF DECEASED <i>John J. Smith</i>	
89. SIGNATURE OF DECEASED <i>John J. Smith</i>		90. SIGNATURE OF DECEASED <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF DECEASED <i>John J. Smith</i>	
93. SIGNATURE OF DECEASED <i>John J. Smith</i>		94. SIGNATURE OF DECEASED <i>John J. Smith</i>	
95. SIGNATURE OF DECEASED <i>John J. Smith</i>		96. SIGNATURE OF DECEASED <i>John J. Smith</i>	
97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF DECEASED <i>John J. Smith</i>	
99. SIGNATURE OF DECEASED <i>John J. Smith</i>		100. SIGNATURE OF DECEASED <i>John J. Smith</i>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU ONE 18



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04621

Reg. Dist. No.

4633

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>7 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS <b>114 West Montgomery Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>B.</b> Last <b>Waters</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/19/75</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>17</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Washington Waters</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 possibly aneurism of abdominal aorta, or coronary thrombosis.</b> DUE TO (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>dissecting aortic aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>9</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>about 1959</b> , to <b>April 6, 1959</b> , that I last saw the deceased alive on <b>April 6, 1959</b> , and that death occurred at <b>3:25 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. A. Linthicum</b>				M.D. <b>26 N. Summit Ave. Gaithersburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. A. Linthicum, M.D.</b>				DATE SIGNED <b>4/6/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Goshen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Goshen, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04622  
Reg. Dist. No.

4634

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2620 Newton St.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1959</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William David Webb</b>		5. SEX <b>male</b>	
6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/9/1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinest</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy yard</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM DAVID WEBB</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIA V. STACKHOUSE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-26-3254</b>	
17. INFORMANT <b>Mrs. Louise N. Webb, 2620 Newton St.</b>		Address <b>Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>4/17/59</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>POPLAR SPRINGS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MT. AIRY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PUMPHREY, INC. Raymond D. Ziska</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoms</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4635

CERTIFICATE OF DEATH

04623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BETHESDA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7602 GLENBROOK ROAD</b>				d. STREET ADDRESS <b>7602 GLENBROOK ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LEONA</b> Middle <b>WECHSLER</b> Last <b>WECHSLER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 1883</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b>		IF UNDER 24 HRS. Hours <b>75</b> Min. <b>75</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>DAVID DICHTER</b>				14. MOTHER'S MAIDEN NAME <b>ESTHER HEINBERG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>ARL. VA. MRS. SYLVIA BERLIN - 4206 COLUMBIA PIKE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.3 Carcinomatosis</b> DUE TO (b) <b>Carcinoma Sigmoid</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Approx 6 mo.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hiatus Hernia with bleeding</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>October 1958</b> to <b>April 19, 1959</b> , that I last saw the deceased alive on <b>4/11/59</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Maurice Mensh MD</b>				ADDRESS (Street, city or town, state) <b>4701-32nd St N.W. Wash D.C.</b>			
PHYSICIAN'S NAME (Type) <b>MAURICE MENSCH MD</b>				DATE SIGNED <b>4/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>APR. 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NEW YORK N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS - 3501-14th St. N.W.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 21 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. K...</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4487

## CERTIFICATE OF DEATH

Reg. Dist. No.

04624

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PK</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> <u>83x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>214 W Alexandria Ave</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Nearl</u> Last <u>Wheatley</u>				4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-29</u>		9. AGE (In years lost birthday) <u>30</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Recreational Supv US Airforce</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>C Amer</u>	
13. FATHER'S NAME <u>Sydney Wheatley</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Wilkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>army</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguinating hemorrhage</u> DUE TO <u>190.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ulcerating, sloughing, malignant</u> DUE TO <u>melanoma of left axilla</u> (c) <u>12 mo.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic lesions of ilium, jejunum, gastric ulcer</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1959</u> to <u>April 15, 1959</u> , that I last saw the deceased alive on <u>April 15, 1959</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace N. Mook</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Avenue</u> DATE SIGNED <u>4/15/59</u>			
PHYSICIAN'S NAME (Type) <u>Wallace N. Mook</u>				<u>Takoma Park 12 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON Co. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Wheatley</u> <u>ALEXANDRIA, VA.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoma</u>	

CERTIFICATE OF DEATH

1922

1151

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1877		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1895		BALTIMORE, MD.		JAMES H. HARRIS		1922		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1922		BALTIMORE, MD.		BALTIMORE, MD.		1922		BALTIMORE, MD.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1922		BALTIMORE, MD.		JAMES H. HARRIS		1922		BALTIMORE, MD.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1922		BALTIMORE, MD.		JAMES H. HARRIS		1922		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1922		BALTIMORE, MD.		JAMES H. HARRIS		1922		BALTIMORE, MD.	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1922		BALTIMORE, MD.		JAMES H. HARRIS		1922		BALTIMORE, MD.	

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

04625

4636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>5420 Conn. Ave N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Anita</b> Middle <b>D</b> Last <b>Whitman</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/8/1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>16</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Francis S. Whitman-Husband-same as 2d</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 21, 1959</b> to <b>April 24, 1959</b> , that I last saw the deceased alive on <b>April 23, 1959</b> , and that death occurred at <b>11:35 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sydney Leventhal</b> M.D.				ADDRESS (Street, city or town, state) <b>9210 Colesville Rd. Silver Spring, Md.</b> DATE SIGNED <b>4/24/59</b>			
PHYSICIAN'S NAME (Type) <b>Sydney Leventhal</b>				9210 Colesville Rd. Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4637

## CERTIFICATE OF DEATH

04626

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>18</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 21</b> d. STREET ADDRESS <b>332 Winthrop Street, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Gail</b> Last <b>YERKES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert J. YERKES</b>		14. MOTHER'S MAIDEN NAME <b>Florence Elizabeth DOREMUS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal atelectasis</b> DUE TO <b>Large congenital polycystic kidneys, bilateral preventing normal excursion of diaphragm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>preventing normal excursion of diaphragm</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity (1 month)</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 24</b> , 19 <b>59</b> , to <b>April 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 24</b> , 19 <b>59</b> , and that death occurred at <b>5:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. L. Walton</b>		ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMCM</b> DATE SIGNED <b>4-24-59</b>	
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-28-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Silver Spring Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Dunham</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION

2051305X44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH Baltimore, Md. CERTIFICATE OF DEATH

NAME OF DECEASED <u>John Doe</u>		AGE <u>45</u>		SEX <u>Male</u>		RACE <u>White</u>	
DATE OF DEATH <u>Jan 15 1925</u>		PLACE OF DEATH <u>Home</u>		CITY <u>Baltimore</u>		COUNTY <u>City of Baltimore</u>	
CAUSE OF DEATH <u>Heart Disease</u>		MANNER OF DEATH <u>Natural</u>		OCCUPATION <u>Teacher</u>		EDUCATION <u>High School</u>	
PREVIOUS ILLNESS <u>None</u>		TREATMENT <u>None</u>		HISTORY <u>None</u>		FAMILY HISTORY <u>None</u>	
SIGNATURE OF PHYSICIAN <u>John Doe</u>		SIGNATURE OF WITNESS <u>John Doe</u>		SIGNATURE OF DECEASED <u>John Doe</u>		SIGNATURE OF NEXT OF KIN <u>John Doe</u>	
DATE OF SIGNATURE <u>Jan 15 1925</u>		DATE OF SIGNATURE <u>Jan 15 1925</u>		DATE OF SIGNATURE <u>Jan 15 1925</u>		DATE OF SIGNATURE <u>Jan 15 1925</u>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES.